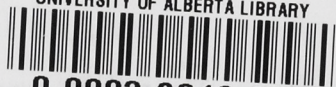


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Perforation Due to Nonpenetrating Abdominal Trauma

A. L. Macdonald, M.D., and E. M. Brown, M.D.

It has long been recognized that non-penetrating trauma of the abdomen can result in perforation of the gastrointestinal tract. Although this is a rare complication, it is one of the most serious. The following report is a review of the literature and a report of a case.

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Case Report

The patient is a 45-year-old male, who was admitted to the hospital on the 15th of January, 1946, with a history of abdominal pain and tenderness. The pain was described as a sharp, stabbing pain, which was located in the right upper quadrant of the abdomen. It was associated with nausea and vomiting. The patient had no history of trauma or surgery.

History of Injury

The patient had no history of trauma or surgery. He had no history of abdominal pain or tenderness. He had no history of nausea or vomiting. He had no history of any other symptoms. He had no history of any other diseases. He had no history of any other conditions.

Mechanism of Injury

The patient had no history of trauma or surgery. He had no history of abdominal pain or tenderness. He had no history of nausea or vomiting. He had no history of any other symptoms. He had no history of any other diseases. He had no history of any other conditions.

Pathology

The patient had no history of trauma or surgery. He had no history of abdominal pain or tenderness. He had no history of nausea or vomiting. He had no history of any other symptoms. He had no history of any other diseases. He had no history of any other conditions.

Discussion

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Conclusion

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Intestinal Perforation Due to Nonpenetrating Abdominal Trauma

S. L. Markovits, M.D., and E. H. Brotman, M.D.

It has long been recognized that non-penetrating injury of the abdominal wall may cause intestinal perforation. Aristotle said "A slight blow may cause rupture of the intestine without injury to the skin." Councillor and McCormack, reviewing case reports available up to 1935, found 1,313 cases reported with an operative mortality of 60%¹. Since 1935 there has been only a slight reduction of these figures. Poer and Woliver² reviewing their statistics up to 1942 in a series of 35 cases give their average mortality as 50%.

Causative Factor

The nature of the injury is varied: (a) kicks, (b) falls on the abdomen, (c) industrial accidents, where the patient is struck on the abdomen by a blunt object; such as an iron bar or a piece of timber, (d) crush injuries from motor car, train or airplane accidents.

Sites of Injury

Hamilton Bailey states that the small intestine is ruptured ten times as often as the large intestine. Fixed points of the gastro-intestinal tract are more vulnerable. These are: The duodenum, the first three feet of the jejunum, the terminal three feet of ileum and the ascending and descending colon on account of the short mesentery.

Mechanism of Injury

All authors agree that a combination of circumstances is at work. This usually consists of a loop of bowel distended with fluid or gas along with trauma acting in a special direction and over a circumscribed area. This tends to pin the bowel against the spine or some unyielding portion of the posterior abdominal wall or pelvic bones³.

Pathology

Since the bacterial count in the intestines increases caudalwards, it follows that the more distal the perforation the greater the danger of infection and contamination. But because in the colon the contents are solid or semi-solid in consistency diffuse peritoneal contamination is less likely to occur than when a small bowel is perforated. An additional factor according to the military manual of the American Medical Corps, is that a great number of bacteria in the large bowel are inactive.

Clinical Classification

Three types of cases present themselves clinically:

(1) Severe multiple injuries which are rapidly fatal and in which treatment is of no avail.

(2) Cases that obviously require immediate surgery.

(3) Cases in which the diagnosis is doubtful, and the indications for or against operation are not clear.

It is in this latter group that the present case belongs.

Diagnosis

Intestinal injury by non-penetrating abdominal trauma is accompanied by symptoms and signs that vary to such an extent that no clear clinical picture can be demonstrated. The intestinal wall is sensitive only to distention, so that perforation by itself creates no symptoms. Usually the onset of peritonitis is the first clue to perforation of a viscus. The signs and symptoms may not come on for hours and in those cases where bruising alone occurs even days may elapse. Poer and Woliver give three mechanical explanations for the delayed appearance of symptoms:

(1) Incomplete rupture: in many instances the injured area sloughs through hours or days later.

(2) Production of intestinal paresis by the injury which inhibits peristalsis for sufficient time to allow an exudate or plastic lymph to seal the opening. After recovery from primary shock or after intake of food, peristaltic action is resumed with consequent leakage.

(3) Mechanical prevention of leakage by plugging of the opening by mucosal layers.

The diagnosis is made from the history of abdominal trauma, signs and symptoms and the X-ray findings. The signs are shock, tenderness, rigidity, increased pulse rate, distention, borborygmi, and fluid in the flanks. The symptoms are pain, nausea and vomiting.

Shock is more marked in hemorrhage than in perforation. There is initial shock which quickly passes off only to return later when leakage occurs.

Pain is the most constant feature noted. The degree varies greatly. In the stomach, the acid gastric juice acts as a severe irritant to the peritoneum and therefore causes excruciating pain while caecal contents are less irritating and produce little pain. Pain may be localized and slight in the early stages, but tends to become increasingly severe and generalized as the disease advances.

Tenderness: Evaluation of this sign is difficult. Quite frequently the tenderness is due to over-distention of the urinary bladder. However, the

(2) The value of thorough abdominal exploration. In this case there was the presence of intestinal obstruction in addition to the perforation.

(3) The use of antibiotics in the peritoneal cavity.

(4) The early use of the Miller-Abbott tube and suggestions regarding its introduction.

(5) The use of the Levine tubes to decompress the stomach of swallowed air and secretion while

the Miller-Abbott tube is well down in the small intestine.

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Tuberculosis

There were three hundred and fourteen tuberculosis deaths in Manitoba in 1945, according to the preliminary figures published recently by the Dominion Bureau of Statistics. The toll in 1944 stood at three hundred and forty-two. This means that the tuberculosis death rate per 100,000 population decreased from 46.7 to 42.7. The fall of four points was due mainly to fewer tuberculosis deaths among Indians; there was very slight difference in the number of deaths in the white population.

While we were essentially holding our own, Ontario established a record low of 25.8. At first glance it would appear that the discrepancy in the figures of the two provinces casts a dim shadow on Manitoba's anti-tuberculosis campaign. But if our Indian deaths were excluded, the rates of the two provinces would be almost identical. And yet, for 1945, as previously stated, we can boast of improvement in the falling rate among Indians, and tacitly admit a standstill for the white population. Besides, it isn't quite fair to blame the Indian for our showing in this respect; after all, this great scourge, which has caused him misery, torment and death, came with the advent of the white man. It is the white man's duty to bend every effort to lift the curse.

That other provinces are winning this grim battle stands as a challenge to all who are concerned with the health of the people of Manitoba. Our reach must be towards the eradication of tuberculosis. If our grasp falls short, it should be deemed a failure, unless we endeavour constantly to increase our efforts.

Ranged against the formidable figure of the annual death toll, stands the impressive array of Sanatoria, clinics, Indian hospitals, Health Units with their Public Health nurses, and lastly, but of tantamount importance, the practitioners. It would be expected that the tide of battle should turn swiftly against the tiny red giant. His annihilation should be easily accomplished. On the contrary, he gives ground slowly and is likely at any time to press the attack. Until our victory is decisive we dare not relax; by our partial success we are paving the way for the subsequent

rapid advance of the red invader. We are on an "immunological hot spot," as Dr. Adamson aptly named it, from which we fear to retreat and seem powerless to go forward.

The soft spot in the armour lies in a dearth of medical and nursing staff. Manitoba has approximately three beds for every tuberculosis death. This ratio is considered adequate under our present circumstances. Many of these beds remain unoccupied mainly because of the lack of nursing care. Encouragement must be given to nurses to enter this important field of the health program. On the contrary we note that some of the questions on the recent examination for practical nurses might stump a fourth year medical student.

Another factor, which precludes a solid front, is late diagnosis of tuberculosis. In spite of the extensive publicity of health education, mass surveys, and examination of all contacts, the majority of patients admitted to Sanatoria are classified moderately or far advanced. Early diagnosis has been stressed to the point where it would seem to be frayed at the edges—and must be stressed still further. The faint and elusive tracing of asymptomatic early tuberculosis crosses and re-crosses the path of every doctor. By continuous and diligent searching, especially in those places where it frequently lies dormant until a crisis occurs, he will be rewarded, either by his discoveries, or by the knowledge that he is above censure. Does he routinely order fluoroscopy or chest films on expectant mothers, diabetics, ischio-rectal abscesses, asthmatics, and so-called chronic chest cases? Does he know that the lungs are clear before he performs a major operation or treats a patient for hyperthyroidism, hypertension, bronchitis, or unexplained dyspepsias? It has been proved, times without number, that a doctor who is especially mindful of any disease will diagnose more cases thereof, whether it be tabes, typhoid, or tuberculosis. The tremendous importance of elapsed time between onset of disease and the beginning of treatment will declare itself strongly on either side of the scales. An early diagnosis may cost the patient ten dollars for the chest film, and the

taxpayer a few hundred for the treatment; the result is a useful member of society. For a late diagnosis the taxpayer forfeits a few thousand dollars and the patient may forfeit his life.

Regardless of presenting complaints, every patient could have a routine Patch test at the first consultation, without expense or inconvenience to himself or his physician. It would be of some value, if the test is negative, to rule out the presence of tuberculosis in any case. The Positive reactor, not previously examined, should have a chest film.

By these methods the practitioner finds the occasional case of incipient tuberculosis. Some definite lesions will be discovered in the mass surveys that are being conducted in the larger centres. The tuberculosis clinics in Winnipeg and St. Boniface, and the Travelling Clinic in Rural Manitoba are constantly checking contacts and suspects—and are bringing to light previously unknown chronic disease as well as new cases of tuberculosis. Another opportunity for case finding, which could easily be exploited may be found in the patients admitted daily to our general hospitals. The medical advisory committee of The Sanatorium Board of Manitoba recently passed a resolution strongly recommending that arrangements be made as soon as possible to provide routine chest films on all admissions to hospitals in this province. The net result of all these factors would locate practically all the tuberculous disease in Manitoba. It would serve three definite purposes; previously unknown cases would be brought to treatment; the spread of disease would thereby be reduced to a minimum; and future examination would be intensified among the known contacts.

If we are going to advocate the finding of all the minimal tuberculosis in the province we will need a definite program of management to ensure proper care of each individual case. We know that there is actually more incipient disease throughout Manitoba than could be contained in all the available tuberculosis institutions. And the beds are already occupied by those who need isolation and treatment. At the same time minimal disease is potentially just as dangerous as the most far advanced. If allowed to progress unobserved it can quickly pass into the open and active phase. The hammer develops a double head, striking vitally at the individual himself and at any with whom he may come in contact.

The keynote then is observation—careful, experienced, and understanding. If this cannot be accomplished outside of institution the patient should be admitted. We will find that the ratio of 3:1 available beds to annual deaths is inadequate. If the program is to be complete a greater number of beds will have to be supplied, especially for the Indian population, to allow for necessary

care and treatment of patients with early tuberculosis.

The practitioner, and more especially the surgeon, can avoid a serious back-fire if he remembers that surgical tuberculosis is a constitutional disease. There are few emergencies. Whether the infection is in kidney, bone, or breast, local treatment in itself serves only to remove one leg of the centipede. The patient requires the more urgent treatment, the local manifestation can be dealt with at an opportune time.

Chemotherapy has been disappointing. The era of miraculous cures has not arrived. Vaccination with B.C.G. vaccine can serve a definite purpose among medical students, nurses, and those whose paths are likely to lead through infested fields. For the latter group it is still more important to seek out and isolate the source of infection.

When the disease has been discovered and successfully treated there is still the problem of returning the individual to society as a useful citizen. The return has to be gradual and guarded in every case. Recurrences are not uncommon and contribute largely to the death rate. Manitoba has one of the best set-ups in Canada for rehabilitation of the tuberculous. This department undertakes to find the job to suit the patient at the various stages of his return to full strength. At the present time a very fine record is being established. Under expert guidance and with the co-operation of the medical advisers, recurrences among those who have returned to work will be held to a minimum.

The program in Manitoba has the chief requisites for an all-out effort. The few deficient details can be supplemented with time and money. More important in the campaign is the co-operation of all concerned with public health. Here lies the duty of the physicians. Every doctor, though he may not realize it, is a member of the anti-tuberculosis league. Without his thoughtful aid there can be no successful completion to the story of tuberculosis. Many have dreamed that they would see the time when Manitoba could number her tuberculous individuals as easily as counting the cases of smallpox. D. A. Stewart had that vision, but failed to reckon with the human factors, the lethargy and indifference which cooled enthusiasm and choked to death the earnest endeavours of those who had developed, like himself, a singleness of purpose. With the beginning of a New Year it would be extremely fitting for all who march under the serpent and staff of Aesculapius, to re-dedicate themselves to the well-being of their fellow-men, including in their avowed the sincere promise to hold high in heart and mind the cross of those who fight tuberculosis.

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The Early Diagnosis of Carcinoma of the Cervix

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Carcinoma of the cervix is the commonest type of malignancy occurring in the female pelvic organs, and if overlooked or untreated is inexorable in its course and inevitably fatal in its termination. For these reasons it constitutes one of the most important of the Diseases of Women.

The mortality of cancer of the cervix, as elsewhere in the body, is usually the result of delay or procrastination by the patient in securing adequate treatment. **Early** carcinoma in this site is a **curable** disease; "more curable" indeed than chronic valvular disease of the heart or nephritis. We have at our command the knowledge and the means to effect permanent cures in a large majority of very early carcinomata. The popular idea of incurability arises from the high incidence of advanced lesions which are, of course, not amenable as a rule to any plan of treatment yet available.

But a second cause of mortality is failure of diagnosis on the part of the physician in the early curable stages. Unfortunately some 80 per cent of patients present themselves (or carcinoma is diagnosed), in the moderately advanced or far advanced stages, less than 20 per cent in the early and earliest stages. The aim of cancer propaganda and medical education is to reverse these percentages.

It is, first of all, important to remember that there are **no** really early symptoms of cervical carcinoma. When symptoms appear it means **ulceration** has occurred, and such a pathological process seldom develops until the growth has existed for a considerable time. Therefore, the only solution to diagnosis in the genuinely early growths—those in the latent (symptomless) and most curable stage—is to spot them by means of routine pelvic examination at periodic intervals. This is obviously impossible on a large scale, but every practitioner could do his own patients and the State a great service by educating women to submit to such examinations while they are still well. After all, the dentist prevents incalculable damage to and loss of teeth by periodic examination, with the treatment of early caries by filling. The majority of women today admit and appreciate the value of annual or semi-annual dental check-ups from a preventative point of view. The case of carcinoma is not only analogous but is of immeasurably greater importance to the individual, for it is not a matter, at the worst, of dentures, but of death.

Turning now to the actual pelvic examination it must be emphasized at once that the existence

of early carcinoma of the cervix is suspected by inspection rather than by digital palpation. He who does only digital examinations will miss many early malignancies, albeit he may miss but few advanced ones. A pelvic examination is not complete until a speculum has been introduced and the cervix and its environs carefully and thoughtfully examined visually under good illumination. Cervical cancer is one of the more accessible carcinomas, much more than Carcinoma of the Stomach, for example, but its accessibility is to vision, not touch.

The chief physical features of early carcinoma are its site, appearance, asymmetry, friability, vascularity, induration, fixity, and progressiveness of growth. The chief symptoms are irregular vaginal haemorrhage and abnormal discharge. Age, parity, race, nationality and pre-existing cervical lesions are factors of lesser significance.

Site—The early cervical carcinoma begins at or near the margin of the external os where columnar meets stratified squamous epithelium. A few cases arise within the cervical canal and fewer still well out from the os, on the portio vaginalis.

Appearance—The lesion may be a solid nodule, a shallow ulcer, a small proliferative mass projecting from the surface or merely a dull red-colored patch unlike the surrounding area. It may be dark red, grey, yellowish or bluish in color. The epithelium may or may not be present over it; if still present it is fixed immovably to it. The surface appears **rough** and irregular.

Asymmetry—Unlike an erosion which surrounds the os, a carcinoma begins at one spot and shows no tendency to develop symmetry.

Friability is one of its most characteristic physical properties. Palpation discloses that the area tends to disintegrate under pressure, and in advanced cases bits of tissue may be torn off. In earlier cases a probe or applicator can be pressed into it without much force instead of, as does normal cervical tissue, retreating elastically before the pressure. (Probe Test).

Vascularity—Most growths are very vascular and bleed **freely** and **persistently** even with the trauma of gentle examination.

Consistency—Even though the surface be friable, most growths at the edge are hard or indurated as compared with normal cervical tissue. This induration extends rather diffusely out into the surrounding areas and thus tends to create **fixity**.

Progressive Growth—Malignant lesions grow fairly rapidly despite all local treatments, cautery, chemicals, excision, etcetera. Hence any apparently benign erosion which fails to heal at expected rate should be viewed with suspicion.

In regard to the symptoms, **irregular bleeding** from the vagina is usual once the surface of the growth has ulcerated. **Intermenstrual bleeding** or spotting (metrorrhagia) and **postmenopausal** bleeding are abnormal in the vast majority of cases and malignancy must always be suspected and excluded as the possible cause in such cases. Bleeding from the trauma of contact, e.g., following examination, coitus, douching, exertion, is highly characteristic of cervical malignancy. (Contact Bleeding). The bleeding may come and go at irregular times, be of variable amount, now light, now heavy, now flooding. There may or may not be clots. There is, in short, no definite course or pattern. However, it is always **persistent** and tends to increase with passage of time.

Vaginal discharge, not due to excess of normal secretions, is a common symptom and may even precede haemorrhage. A change in type, if discharge had been present previously, or a rapid increase in amount, are common complaints. Any blood-stained discharge is very suspicious; at first rather watery and irritating, it later becomes thicker and more foul and resembles dirty dish water, even with pieces and bits of tissue in it. (The appearance of discharge usually means infection has become superimposed on ulceration).

Biopsy—The final court of appeal and the only certain and scientific method of absolute diagnosis lies in excision of a specimen of growth and its submission to the pathologist for microscopic study. Such a procedure is simple, safe and certain, and constitutes the method of **Biopsy**; not only is the diagnosis confirmed definitely, but the type (epidermoid or adenocarcinoma) and the grade (Broders 1 to 4) are at once determined and may be helpful in indicating modes of treatment.

Endocervical carcinoma with normal portio is discovered usually by dilatation of external os and curettage of cervical canal. This is a commonly overlooked site of this lesion.

Biopsy can be done in a majority of cases in the office. A special biopsy scissors or punch is useful but not indispensable. Scalpel or scissors followed by cautery will suffice. The danger of causing metastasis is much less than the danger of overlooking or missing the diagnosis. Some haemorrhage is about the only complication and either cautery or tampon will take care of it. Pathologists like to have a piece of normal tissue at the edge for comparison and study of invasive-

ness. A generous block should always be excised. "Pin heads" of tissue try the patience and ability of the pathologist unnecessarily. Specimen bottles containing 10% Formalin are usefully kept with labels to receive and despatch these important specimens.

Finally, this resume cannot be concluded without brief reference to the more advanced and refined methods of diagnosis. I refer to Schiller's test, colposcopy, and the study of vaginal and cervical smears as first advocated by Papanicolaou. These methods are of use in certain instances, but in all, biopsy is often needed for confirmation—hence it may logically be used at the outset. Secondly, they require special and experienced interpretation by those with large knowledge of the special method used; and lastly, they are not always available when most needed, whereas biopsy always is. Indeed the diagnosis of cancer of the uterus is amazingly simple when reduced to its fundamentals, namely, curettage to detect carcinoma of the body, excision and biopsy for carcinoma of the cervix.

The early diagnosis of Carcinoma of the Cervix depends then on:

(1) Routine pelvic examination in as many female patients as possible who are being studied or treated for extra-pelvic complaints.

(2) Periodic pelvic examinations in women past thirty or thirty-five years of age.

(3) Complete and careful pelvic examination in all cases with gynecological complaints, especially irregular bleeding and/or discharge. This implies a thorough inspection of the cervix plus rectal palpation as well as the usual bimanual examination.

(4) Biopsy examination of all suspicious cervical lesions.

(5) Pathological examination of all cervixes removed at hysterectomy or conization.

The early diagnosis must be followed **without delay** by correct and adequate radiation treatment, and all treated cases observed thereafter at definite intervals for follow-up examinations.

(6) Finally we must make every effort to eliminate the common reasons for delay in patients seeking advice with possible cervical carcinoma. These are mainly ignorance, indifference, fear, modesty and indigence. More emphasis on these factors in cancer publicity, in the teaching of medical students, and in the conduct of such cases in general practice, would do much to reduce the time-lag between the onset of symptoms and the initiation of treatment.

Constrictive Pericarditis

Dr. M. B. Perrin

History

The local evidence of pericardial constriction is associated with other changes in the body, both of primary and secondary importance. Pick's disease is a title frequently used in this connection, although priority belongs to Richard Rower (1669). He clearly recognized the syndrome with the failure of the heart to relax fully in diastole as being the principal factor in the defective cardiac output. The work of two English physicians also merits recognition—Chevers (1842) found no evidence of rheumatic origin of the pericardial adhesions. Wilks (1871) noted, "In a well marked case of disease with cardiac symptoms in a young person without any valvular bruit pericardial adhesions may be fairly expected." The use of the name of Pick (1896) in connection with constrictive pericarditis is the outcome of a series of cases in which he differentiated between liver cirrhosis associated with pericarditis and the enlarged liver of polyserositis.

The first surgical attempts to obtain freedom of the restricted heart was Brauer's cardiolysis, and was based on faulty diagnosis, i.e. the failure to differentiate between (a) mediastino-pericarditis and (b) constrictive pericarditis. In (a) we find an enlarged heart, fixed apex beat, systolic recession and diastolic shock, while in (b) we have a small heart, no recession, no diastolic shock, and a relatively quiet heart. In 1923-6 Volhard and Schmiedeu published a series of cases. In 1929 Churchill published his case which stimulated the English speaking world, and figures and accounts have been published by Blalock and Burwell, Beck, Heuer and Harrington.

Classification

There are three conditions that come under pericardial adhesions:

1. Bands or fine adhesions in pericardial sac.
2. Mediastino-pericarditis.
3. True constrictive pericarditis.

It is with the last that we are dealing.

The chief effect of the fibrosis is to limit diastole, and therefore the heart cannot accept the full amount of blood. It is important to realize that no matter how small the veins coming to the heart, an efficient circulation can be maintained if the heart chambers are normal. This is shown surgically, for when the ventricles are released the condition improves.

On the arterial side of the circulation the diminished systolic output is recognized by a low systolic blood pressure and a low pulse pressure. In response to exercise, instead of an increased stroke volume we find a markedly increased rate,

so that tachycardia becomes prominent. Dyspnoea similarly occurs early—not present at rest or lying.

The most significant feature of the condition is a raised venous pressure, a direct response to the reduced heart output. In a chronic compression the venous pressure in the right auricle can reach a figure of 300-400 mms. of H₂O. This back pressure leads, of course, to dilatation of the peripheral systemic veins, seen as dilated veins over the body. Venous pulsation is a feature.

Other effects of this pressure are:

1. Oedema of dependent parts.
2. Enlarged liver—soft, tender.
3. Ascites—marked.
4. Abdominal discomfort—anorexia.
5. Pleural effusion—this is more likely due to polyserositis and an exudate.

N.B.—The lungs are unaffected; this therefore is different from ordinary heart failure. (In surgical intervention, free the left ventricle first so as not to embarrass lungs).

State of the Heart

The heart muscle is normal in nearly every case. However, there is evidence that the muscle does not function 100% after it is freed, but gradually over some months the muscle will become 100% normal.

Fluoroscopy

1. Small heart—but not necessary.
2. Quiet heart usually.
3. Increased width at upper part of heart.
4. In one-quarter to one-third cases calcium plaques or bands appear.

Aetiology

Rheumatism has been ruled out. In this disease the adhesions are vascular with loosely packed wavy collagen fibres.

Three possible causes:

1. Tuberculosis.
2. Pyogenic.
3. Idiopathic. This forms the largest group.

White reports an interesting finding on one of Churchill's cases. At the first operation tuberculous tissue was found, but on re-operation only fibrosis was present.

Sellers reports twenty cases, and in sixteen tuberculosis was the cause.

The effect of chronic pericardial inflammation is most marked in the initial stages on the parietal layer but later it is the visceral layer which becomes the constricting agent.

The future of a patient with constrictive pericarditis depends on the rate of development of the condition. If slow in development these patients can live for many years with tolerable health; but

they have increasing distress and face a pretty gray future.

Medical Means of Control

1. Limited exertion.
2. Effusions aspirated.
3. Low fluid intake.
4. Mercurial diuretics.
5. Rest.

Surgery

Subject to the ability of the patient to withstand the operation, every case of true constrictive pericarditis is eligible for surgical consideration.

Preparation

1. Rest.
2. Relief of fluid pressure in cavities.
3. Limit fluid intake.
4. Low salt intake.
5. High protein diet.
6. Digitalis contraindicated—many use quinine.

Anaesthesia: Intratracheal ether or cyclopropane.

Operation: Two approaches—(a) Extra pleural. (b) Intra pleural.

Effects of Pericardiectomy

Some immediate lowering of venous pressure. A lowering of venous pressure and reduction of ascites and liver size may be noted within a few weeks but full and final improvement should not be expected up to 12 and 18 months. There are cases who have returned to full laboring work, but most of them follow a quieter life. The type of operation also will determine the "cure."

Case Report

Stanley P., aged 22—This young man was perfectly well until 1941, when he noticed swelling of the left leg followed by swelling of abdomen and scrotum. He was examined by medical men and treated by means of diet, restriction of water, and injections to increase output. During the years from 1941 until 1946 he had been treated by diet, aspirations of cavities and salyrgan injections.

He was seen in July of this year because he was returning for removal of fluid from the abdomen and the investigation at that time showed the following: Tall, sallow boy with large protuberant abdomen, swollen legs, swelling of scrotum and large umbilical sac. He had obvious venous congestion in the neck, chest and abdomen. Blood pressure 110/68, heart enlarged slightly, no murmurs, rate 100.

Laboratory tests showed a hypochromic anaemia. Sedimentation rate 20 mms. in one hour. Blood proteins low. Venous pressure 27.5 cms. or 275 mms. Circulation time was prolonged. Cephalin flocculation test was negative. Liver function tests were normal.

A diagnosis of constrictive pericarditis was made and the patient was prepared for operation by rest in bed, restricted fluid intake, low salt intake, removal of fluid from abdomen, and high protein diet.

On August 30, 1946, a pericardiectomy was performed. Under intratracheal cyclopropane—patient lying flat on back with left arm at right angles to body. Incision was along 2nd left costal cartilage and rib, extending from anterior axilla to mid-sternum, then down sternum to 6th costal cartilage, along the cartilage and rib to anterior axilla. This flap of skin, subcutaneous tissue and muscle was raised and thrown laterally. Lengths of 3rd, 4th and 5th costal cartilage and piece of rib excised, internal mammary artery identified and tied at upper end and lower end of vertical incision. This now allows periosteum and muscle bundles between the ribs to be thrown back from medial to lateral position. The pleura presents and one can gradually push this away from pericardium or enter pleural sac immediately and work from there. The apex and lateral side of heart is examined, because it is here one starts dissecting. By incisions into fibrous pericardium down to the myocardium, one can usually find a plane to dissect along—pieces of tissue are cut away, always leaving a good piece to use as retractor or to quickly cover over a defect made into myocardium as one dissects. By gradually using blunt and sharp dissection, the apex and a good sized piece of the left ventricle is freed and allowed to bulge anteriorly. The dissection then can proceed along diaphragm surface of heart and over right ventricle. It is a tedious dissection and one must rest the heart from time to time; I place hot packs in it. Finally a satisfactory removal of fibrous pericardium has occurred, the flap of intercostal muscles is laid back and sutured to its own medial ends, over this the muscle part of flap and then skin. The chest is aspirated and air removed until a positive pressure is present. Post-operative course was smooth. He was given oxygen by means of a tent for the first three days. Blood was withdrawn from the chest on three occasions. The first improvement noted was that a few hours following the operation the venous pressure was lower and the swelling in the left was reduced.

September 3, 1946: Venous pressure 120 mms. much less swelling of legs.

September 9, 1946: Venous pressure 90 mms. Much less swelling of legs.

September 11, 1946: Venous pressure 62 mms. Much less swelling of legs.

September 13, 1946: Venous pressure normal. Patient shows striking improvement, no demonstrable ascites, scrotal oedema subsided, liver not palpable and there is no flaring of the rib margins.

He now shows considerable muscle wasting and two large inguinal hernias into the scrotum and one large umbilical hernia.

December 4, 1946: The boy now appears in perfectly good health, is tall, thin, good color, alert and shows no evidence of fluid in abdomen—no enlarged liver, no edema—and is able to look forward to a useful life.

Case Reports

A Case of Fallot's Tetralogy, Treated by The Blalock-Taussig Operation

This child, a patient of Dr. L. W. Reznowski, was presented recently at the Ward rounds of the Children's Hospital of Winnipeg and is reported here as this is the first case in Manitoba to be treated in this way.

Presentation by Dr. Reznowski

Myron H. was born on November 4, 1940. His birth was normal and easy in all respects, while in the hospital his progress was normal and there was nothing to draw one's attention to his heart. When he was six weeks of age his mother noticed that he had a sallow complexion and that there was a reddish blue tinge of the skin below the eyes. The mother brought him to me and I noticed a loud systolic blowing murmur all over the chest and best heard over the left third interspace. At 14 months of age when he was learning to walk the mother noticed that the lips were cyanotic when he cried. Myron gradually became more cyanotic as he grew up and was unable to play with the other children, having to sit on the curb and watch them, because on running a few feet he would become markedly cyanotic and dyspnoeic. During the two years before operation his condition was becoming much worse with a greater degree of cyanosis and dyspnoea on exertion. Even at rest the cheeks, lips and fingers were cyanotic and there was considerable clubbing of his fingers.

In February, 1946, a blood count showed 14,500,000 R.B. C's and the hemoglobin 45%. In May, 1946, he was taken to Johns Hopkins University Hospital, Baltimore. The following is a letter from Dr. Helen Taussig:

May 11, 1946.

"Myron is a little 5½-year-old white boy referred to us from Winnipeg, Canada, hoping that we will be able to help him. He shows definite persistent cyanosis which was first noticed at 1½ months of age, when he began to learn to walk, at 2 years of age he had severe spells, but since then he squats down when he is tired, he can walk half a block to a block if he does it slowly.

"Physical examination: He is a bright little cooperative boy who is definitely cyanotic. His

heart is not enlarged. Apex beat is in the 5th interspace in the midclavicular line. There is a definite precordial thrill and a harsh systolic murmur.

"Under the fluoroscope his heart shows a contour characteristic of the Tetralogy of Fallot. It is not enlarged. There is a fullness of the pulmonary cone. There is a definite right aortic arch with the esophagus swinging slightly to the right and indented on the left, and there are no pulsations in the lung fields.

"I think he does have a Tetralogy of Fallot and would be benefited by operation. It would be a good operation and should be performed on the left with a subclavian to the left pulmonary artery. He is in good condition now, and is staying on the outside and will be admitted to the hospital just as soon as we have an opportunity for operation."

"P.S.—Operated on this a.m., May 17, 1946.

(Signed) Taussig

Doing well.—H. B. T."

"Operation: May 17, 1946. Dr. Alfred Blalock, Cyclopropane, Ether. Anastomosis between the end of the left subclavian and the side of the left pulmonary arteries.

"This boy showed a moderate degree of cyanosis. He is patient No. 136 in this series.

"The patient had a right aortic arch and hence the incision was made on the left. It extended from the edge of the sternum to the mid-axillary line. Bleeders were ligated with silk. The pleural cavity was entered in the third interspace. The third costal cartilage was divided. A rib spreader was introduced.

"The left pulmonary artery was exposed. It was a fair sized structure. The pulsations were not vigorous. The pressure was measured and found to be 230 mm. of water. Anastomosis was decided upon.

"We then explored in the region of the innominate artery which was directed to the left. It divided into the left common carotid and the left subclavian. The left subclavian was freed of surrounding tissues. It was ligated distally. It was occluded proximally with a bulldog clamp. It was cut across proximal to the ligature. It was freed of adventitia.

"Attention was turned again to the left pulmonary artery. It was occluded proximally with a large Murray-Baumgartner instrument and distally by traction on braided silk around the individual vessels. A transverse opening was made between the points of occlusion.

"Using 5-0 Deknata sutures an anastomosis was then made between the end of the left subclavian and the side of the left pulmonary. The suture line was interrupted in four places. It was

than an easy anastomosis and no difficulty was encountered. There was very little bleeding following the removal of the constricting devices. A good thrill could be felt in the pulmonary artery.

"The mediastinal pleura was closed with interrupted silk sutures. The third and fourth ribs were approximated with an encircling suture of E. silk. The tip of a catheter was placed in the pleural cavity. The muscle, fascia, subcutaneous tissue and skin were closed with interrupted silk sutures. The catheter was aspirated and removed. The patient's condition at the end of the operation was very good. He should get a good result."

Alfred Blalock.

Convalescence following operation was excellent. Since returning from Baltimore Myron is like a new boy. He is more happy and is able to run around and play with the other boys, although, if he runs a lot his lips become slightly cyanotic and he becomes dyspnoeic. A blood count done Nov. 28th, 1946, showed 6,000,000 R.B. C's and Bb. 97%, which is a good criterion of the improvement in his pulmonary vascular circulation.

We wish to add that in July, 1946, Myron had lobar pneumonia and in December, 1946, bronchopneumonia. He showed good response to chemotherapy and recovered promptly on both occasions.

Discussion By Dr. H. Medovy

The commonest type of congenital heart malformation associated with permanent cyanosis is the Tetralogy of Fallot, in which there are four associated abnormalities — an overriding aorta which receives blood from both ventricles, a defect in the upper part of the inter-ventricular septum, a stenosis of the pulmonary artery and an enlargement of the right ventricle. The object of the Blalock-Taussig operation is to increase the amount of blood going to the lungs. This is done by creating an artificial shunt between the subclavian or innominate artery and the pulmonary artery distal to the stenotic area. In successfully operated cases the oxygen saturation had risen from 30% to as high as 80%. It is necessary to be sure that there is actual stenosis of the pulmonary artery. There should be an absence of the fullness of the pulmonary conus in the P-A chest plate and the pulmonary "window" should be clear in the left anterior oblique plate. There should be no evidence of pulsation of vascular shadows in the fluoroscopic examination.

The ideal age for surgery in these cases is between two and nine years. The mortality rate in this group is about 20% in the Baltimore series of some 250 cases. The risk is much greater in the older age group although the mortality rate has fallen even in this group in recent weeks.

In the cases successfully operated upon there is a rise in oxygen saturation of the blood, a marked decrease in cyanosis and clubbing and an increase in the ability to carry on normal activity. The patients carry on much more normal lives even though the underlying cardiac abnormalities remain. The cyanosis does not disappear completely in view of the fact that there is still an admixture of blood from both ventricles going into the over-riding aorta.

The Blalock-Taussig operation marks one of the most important therapeutic advances of the century.

Strangulated Umbilical Hernia Complicating Pregnancy

Dr. W. C. Newman

The patient, a white female of 33 years, was first seen at her home on October 4, 1945, at about 3.30 p.m. Her complaints were as follows:

1. Pain in the region of the navel for three hours.
2. Tender lump in the region of the navel for three hours.
3. Repeated vomiting for two hours.
4. Amenorrhea since May 6, 1945.

Past history was essentially negative. The patient had known of the presence of an umbilical hernia for five years—since her third pregnancy in 1940. It had never before caused her any trouble.

On examination the uterus was found enlarged to the size of a five months pregnancy. Fetal parts and movements could be felt.

At the umbilicus there was a tense, tender mass, 1½ inches in diameter, and raised 1 inch above the surrounding skin—evidently a strangulated umbilical hernia.

Gentle taxis after Morphine Sulphate, gr. ¼, failed to reduce the hernia. At 6.30 p.m. the hernia was repaired by the Mayo "vest-over-pants" method using interrupted sutures of No. 1 chromic. The sac contained 4 inches of purple, but viable, small bowel protruding through a fascial defect ½-inch in diameter.

Following the operation, Proluton 10 mgm was given by intramuscular injection daily for 10 days. Fetal movements became evident again on the third day post-operatively. Sutures were removed on the tenth post-operative day and the patient was discharged on the seventeenth day. Convalescence was uneventful.

On February 14, 1946, the patient was delivered of an 8-pound, 2-ounce viable male child. Forceps were not used. Labor and puerperium were normal.

When the patient was last seen on May 20, 1946, there was no evidence of recurrence of the hernia and the patient had no complaints.



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Section of Anaesthesiology

P. C. Lund, M.D., Anaesthetist, Deer Lodge Hospital

Next Meeting January 7

The next meeting of the Winnipeg Anaesthetists' Society will be a dinner meeting at the Medical Arts Club at 6 p.m. Tuesday, January 7.

Programme

1. The Pharmacology of the Autonomic Nervous System . . .
By Professor M. J. Ormerod.
2. Round Table discussion—The choice of Anesthesia for exploration for Nucleus Polposus.
3. A discussion of post-operative fatalities.

Report

At the last meeting of the Winnipeg Anaesthetists Society Dr. J. D. Adamson, Professor of Medicine, presented a most interesting and instructive paper entitled "The Preoperative Evaluation of Risk and the Treatment of Pre and Post Operative Chest Complications."

Dr. Adamson stressed the importance and value of the anaesthetist sharing in the pre and post operative care of the surgical patient. He also pointed out that the anaesthetist is probably the only man in the team who knows, or in any case should know, the exact pharmacological actions of the various anaesthetic agents and thus, in this particular regard at least, should be better qualified than a surgeon or internist to evaluate pre-operative risk. A brief review of the diagnosis and modern therapy of post operative complications was also presented.

P. C. L.

Abstract

Cardiac Pathology as related to Anesthesia. California and West. Med. 63:218-220 (Nov.), 1945. Langsdorf, G. C.

Marvin has pointed out that the most helpful evidence we can obtain regarding the heart's functional condition is the record of its response to what might properly be termed the stress and strain of daily life: the walking, the running, the stair climbing, the periods of emotional excitement, the innumerable mental and physical activities in which we daily indulge. If the history

reveals breathlessness on exertion, orthopnea requiring the use of two to three pillows, cough and ankle edema, physical examination takes on an increased importance. Such an examination then should include a determination not only of blood pressure, pulse, and cardiac thrills, murmurs, rate and rhythm, but also of venous distension, cyanosis, location of apex beat, basal rales, pleural effusion, liver enlargement, ascites and ankle edema. In addition to the routine urinalysis and blood counts, special examinations may properly include sedimentation rate, circulation time, venous pressure, electrocardiograms, and fluoro-scopic. If such an examination shows the presence of mild to moderate congestive failure, operation should be delayed, if possible, and adequate pre-operative cardiac treatment instituted.

Given a patient with moderate to severe congestive heart failure and in need of immediate surgery, the preoperative preparation should be instituted as soon as possible. During this preparation, oxygen by mask, catheter, or tent should be administered continuously to insure adequate oxygen supply to the myocardium. Phlebotomy should be done, drawing off 400 to 700 ccm. of blood, the amount depending upon the severity of the patient's decompensation and his red blood cell and hemoglobin level. This blood, collected into a sterile bottle containing the proper preservative and stored at 4°C., later may be given back to the patient during operation if needed. (The abstractor feels that frequently a more rational procedure than phlebotomy is to treat the congestive failure with a spinal anesthetic (which decreases peripheral resistance and causes a pooling of the blood in the blood vessels of the lower abdomen and extremities and decreases the venous return to the heart, these and other factors relieve the pulmonary congestion.) Following the phlebotomy, digitalization may be rapidly obtained by the intravenous injection of 8 ccm. (1.6 mgm.) of Cedilanid. This then may be followed by the average daily oral maintenance dose of 0.5 to 1.6 mgm. of Cedilanid. The administration intravenously of a mercurial diuretic, such as salygran or mercupurin, and perhaps 25 to 50 ccm. of 50 per cent dextrose may be advisable. Also any appreciable pleural effusion or ascites should be aspirated prior to the surgical procedure.

Patients with heart disease of practically all types (congestive, rheumatic, hypertensive, coronary, thyrotoxic) withstand anesthesia and surgical operation amazingly well, even with auricular fibrillation, slight angina pectoris or mild congestive

tive failure, if care is observed. However, marked congestive failure, recent coronary thrombosis, severe angina pectoris, complete heart block and syphilitic heart disease with aortic insufficiency, all of which notoriously are apt to lead to sudden death even with the patient at complete rest, add considerably to the operative risk. In such cases elective surgical procedures should be avoided.

The anesthetist on occasion may be confronted by a patient who is sick with acute rheumatic fever, and yet needing emergency surgery. In evaluating one of these patients preoperatively, it is particularly important not only to check him for symptoms and signs of cardiac decompensation, but also for pericardial effusion and any pulmonary or pleural involvement. When found, the effusion fluid should be aspirated prior to any emergency anesthetic and surgical procedure.

An important type of heart disease, not uncommonly met by the anesthesiologist, is so-called "thyrotoxic heart disease" occurring in the 20 to 40-year age group. The standard preoperative administration of 5 grains of potassium iodide or 5 drops of Lugol solution three times daily for a week usually slows the heart rate. Auricular fibrillation, common in thyrocardiacs, is not a contra-indication to general anesthesia or surgical operation, but if there is time, it is wise to attempt first to control the arrhythmia by the administration of quinidine or digitalis. Often it will be difficult or impossible to control the auricular fibrillation until the thyrotoxicosis is corrected by operation. During the years since 1912, cases of myocardial infarction have been recognized more and more frequently. Elective surgical procedures should be avoided on such patients until two to three months after their sedimentation rate returns to normal, their electrocardiograms have become stabilized, and the patient is out of bed and about his daily activities. Hypertensive heart disease is the most common and important of all types of cardiovascular disease. From the anesthesiologist's standpoint, patients with arterial hypertension are definite risks, since frequently a dangerous fall in blood pressure may follow the administration of a spinal anesthetic, and cerebral or coronary accidents may occur during a rough excitement stage in the course of induction with inhalation anesthesia. Cardiac arrhythmias may cause the anesthesiologist concern. One of the commonest arrhythmias encountered in daily life, is the simple premature systole, usually of ventricular origin. The appearance of frequent ventricular premature systoles following an acute myocardial infarction is considered by some cardiologists to be an indication for the immediate administration of quinidine in an effort to prevent possible ventricular fibrillation. Chloroform and cyclopropane may produce

premature systoles, paroxysmal tachycardia, and in experimental animals, ventricular fibrillation and death. The sudden death of patients during anesthesia with these two agents is thought to have occurred through this mechanism. The matter of arrhythmias in relation to cyclopropane anesthesia has been submitted to extensive study by various investigators.

A number of drugs, including barbiturates, procaine, morphine, atropine, and quinidine, have been utilized without consistent success in the prophylaxis and treatment of these arrhythmias during cyclopropane anesthesia. Even during routine anesthesia with ether, premature systoles, paroxysmal tachycardia, and disturbances of the sinoauricular pacemaker are not uncommon. Usually they are of little importance, but the rapid pulse of paroxysmal tachycardia may cause alarm. Generally, the tachycardia subsides spontaneously although it may require carotid sinus pressure. If that is unsuccessful the intravenous administration of Cedilanid, or quinine may be advisable, although it is doubtful if this would be necessary during the average operation.

Altogether, the problem of an ideal anesthetic for cardiovascular cases is controversial. One of the prime factors in deciding upon an anesthetic procedure, for a given case will be the anesthesiologist's experience with a given method thus avoiding undue emotional trauma to the patient in regional anesthesia and insuring a smooth induction and maintenance during general anesthesia. Collapse or death during anesthesia and surgical operations is rarely due to heart disease. The rare case of cardiac arrest should be treated by: 1. Artificial respiration by means of rhythmic pressure on the rebreathing bag of a closed circuit with an endotracheal tube in place, and 2. Artificial circulation by means of rhythmic direct manual compression if the abdomen is open. Otherwise, the thrusting of a needle through the right third intercostal space parasternally into the right auricle of the heart may initiate cardiac activity. Postoperative cardiovascular complications may include paroxysmal tachycardia, paroxysmal auricular fibrillation, coronary thrombosis, and congestive heart failure. More common postoperatively than a serious cardiac complication is the not uncommon complication of pulmonary embolism which may give rise to an acute cor pulmonale which may be confused with coronary thrombosis or acute pulmonary edema of cardiac origin. The occurrence of pulmonary embolism demands the immediate investigation of the lower extremities for venous thrombosis, by means of diodrast venogram if necessary, and ligation of the thrombosed vein if one is found.

P. C. L.

Clinical Luncheon Reports

Winnipeg General Hospital

A Neuro-Surgical Case — Dr. Hugh Cameron

December 4, 1946.

Mr. G. F. G., aged 60, admitted to Winnipeg General Hospital on February 1, 1946, care of Dr. John McEachern.

History: On October 21, 1945, at 7 a.m., suffered a generalized seizure, lasting 20 minutes. Post-ictal: Residual weakness right face and extremities, some thickness of speech. Rested for 10 days.

December 21, 1945: Again in bed, milder seizure. Total recovery after 2 hours. Both seizures witnessed by wife. All extremities involved. Otherwise patient has been in good health and no complaints. General physical and neurological examination negative.

February 2, 1946: X-ray Skull, negative. Pineal calcified and not displaced. Electroencephalogram reported by Dr. Rice: "Strong evidence of an expanding or degenerating lesion involving anterior temporal or lower border of left frontal lobe."

February 4, 1946: Lumbar Puncture—Initial pressure 170. C.S.F. negative. W.R. negative. Fundi and Visual Fields, Dr. Washington considered normal.

February 5, 1946: Pneumoencephalogram advised.

February 7, 1946: Pneumoencephalogram reported—"Septum pellucidum and third ventricle shifted moderately to right. Anterior portion of left temporal horn displaced backward and tipped upward. There is elevation of the left insula. There is an expanding lesion involving anterior portion left temporal lobe." (Dr. A. E. Childe).

February 8, 1946: Chest plate, negative.

Feb. 11, 1946: Left fronto-temporal craniotomy. Encapsulated tumor, size of an egg, removed from left middle cranial fossa arising from lesser wing of sphenoid. Tumor soft and vascular.

Biopsy: Meningioma (meningeal fibro-blastoma).

Convalescence uneventful. Allowed up on 8th day.

Discharged on 14th day post-operative.

Comment

This case is being presented to emphasize the importance of carrying out a careful investigation in a patient suffering epileptiform seizures. He had no headache or other complaints and his physical examination was quite negative.

The diagnosis and localization of a brain tumor was made with the assistance of the electro-

encephalogram and pneumoencephalogram, following which an innocent tumor was successfully removed. The patient has made a very satisfactory recovery.

Hepato-Jejunostomy for Stricture of Common Bile Duct

P. H. T. Thorlakson, M.D.

Mrs. F. C., Hospital No. 10950, age 53.

Past History: Mother of 17 children, youngest 11 years. Cholecystectomy, June, 1946, for repeated attacks of biliary colic—no history of jaundice prior to operation. There had been drainage of bile immediately after the operation but the incision subsequently had healed completely.

Entrance Complaint: Reported first for examination on August 15, 1946, complaining of jaundice, pale stools and the loss of twenty pounds weight since operation, and hematuria for two weeks.

Physical Examination: Nothing significant except deep jaundice; marked hypertension (235/120); and palpable, tender edge of liver.

Laboratory Reports: Urinalyses showed blood cells, which cleared after Vitamin K. therapy. Blood Count R.C. 3,670,000, Hg. 72%, W.C. 6,200. Sedimentation rate 100 mm. mercury. Prothrombin time 15 secs.—50% of normal. Icterus Index: On admission to hospital, 74.

Pre-Operative: Preparation included the administration of Vitamin K intravenously, forced glucose drinks, and grouping and matching for blood transfusions.

Operation: Performed August 21 under intratracheal cyclopropane and intravenous curare.

Exploration revealed that the common duct had been completely destroyed right up to the hilum. At this point there was no dilated sac; but only dense, fibrous tissue.

A long needle was inserted through this mass of scar tissue fully half an inch into the liver at this point before striking white bile. The needle was left in place and the tract enlarged by passing a narrow bistoury knife along the needle.

A vitallium tube was inserted into the liver and fixed in place by a silk suture; then a loop of jejunum was brought up through the transverse mesocolon to the right of the mid-colic artery and a small opening made at the apex of this loop for the insertion of the one end of the vitallium tube.

The small bowel was fastened to the under surface of the liver by a row of silk sutures, making use of the dense, fibrous tissue at the hilum of the liver for this purpose.

A lateral anastomosis between the two loops of small bowel was performed below the transverse mesocolon, and this completed the operation.

Post-Operative: Convalescence was uneventful. Her temperature reached 100 for the first three days and then settled to normal and remained normal. The highest pulse recorded on the chart was 100, settling down to 86 on the third day. The jaundice gradually improved; the last icterus index before leaving hospital was 26.

Discharged from Hospital September 11, 1946, her icterus index was re-checked at the Winnipeg Clinic on October 6 and was found to be 7. Since that time she has been completely free of symptoms. X-ray films, made post-operatively, show the vitallium tube still in place.

Monthly Clinical Meeting—Deer Lodge Hospital Residual Disabilities in Hong Kong Repatriates

The 1946-47 series of Monthly Clinical Meetings at Deer Lodge Hospital began with a meeting on October 30th.

Dr. J. D. Adamson presented a paper on "Residual Disabilities in Hong Kong Repatriates." Over four hundred of these men have been studied by the medical staff of Deer Lodge Hospital since their return from Japan a year ago. The findings in 300 cases have been analysed with the idea that careful clinical investigation of these men might throw some light on various symptoms which are commonly attributed to avitaminosis.

As a background Dr. Adamson referred to a report written by Lt.-Col. John Crawford and Major J. A. G. Reid, medical officers of the Canadian forces in Hong Kong. All of the prisoners experienced a greater or lesser degree of morbidity largely due to a combination of four important factors: (1) Abrupt reduction in rations to a diet grossly deficient especially in total calories, fat, animal proteins and Vitamin B complex; (2) continual infection, dysentery, malaria, diphtheria and parasitic infestation; (3) forced exhausting labor; (4) completely inadequate medical supplies and equipment. The chief evidences of deficiency were emaciation, peripheral neuritis, oedema, cardiac symptoms, lesions of skin and mucous membranes, and visual disturbances.

Among the group studied the incidence of common symptoms and signs are summarized as follows:

Table 1
Incidence of Common Symptoms

	No.	%
Anorexia	147	49
Gastro-intestinal Complaints	180	60
Perspiration	228	76
Eyes (Subjective)	145	48
Cardiovascular (Subjective)	217	72
Paraesthesias (Feet and Legs)	250	83

Table 2
Incidence of Common Signs

	No.	%
Absent Tendon Reflexes	60	20
Impaired Vibration Sense	69	23
Impaired Light Touch	64	21
Impaired Deep Touch	25	8
Impaired Superficial Pain	78	26
Impaired Deep Pain	30	10
Impaired Position Sense	40	13
Impaired Temperature Sense	66	22
Positive Romberg Sign	69	23
Optic Atrophy	79	26

Anorexia and other gastro-intestinal symptoms commonly appeared after an interval of ravenous appetite and general high living immediately following liberation. These symptoms are now gradually lessening and are seldom associated with any discoverable physical findings. Gastric analysis departs only slightly from the normal. It is generally considered that Vitamin B deficiency produces gastro-intestinal atony as a result of vagal involvement. The symptoms these men developed suggested hypertonicity and may represent a phase in the regeneration of normal nerve supply. Rather surprisingly, only one of the 300 developed a peptic ulcer (duodenal) while in Japan. Possibly the low diet and defective hydrochloric acid secretion prevented ulcer formation.

Abnormally profuse sweating was a common symptom (76%). No conclusive correlation could be established between this and any of the other common symptoms.

Cardiovascular symptoms (dyspnoea, palpitation and precordial pain) are very common but there are no signs of permanent cardiovascular damage. On first return some men still had oedema, and this was attributed to the heart as by the time they were studied the blood proteins were normal. Only one case was seen with the classical evidence of Beri-beri heart (general enlargement of the heart shadow, low E.C.G. amplitude, oedema not otherwise explained).

Paraesthesia was the commonest symptom, almost always bilateral, symmetrical and limited to the feet and legs. This usually starts with burning "hot feet," goes on to prickling and stabbing pain "electric feet," and finally the parts become numb. It is very slow to disappear, and during recovery may go back through all the stages. In many cases the paraesthesia appeared to become worse after the men returned to Canada. Many of these patients had positive neurological findings as shown in Table 2, but also a few with such signs as absent knee jerks had no paraesthesia. The site of the neurological lesion is open to speculation, but it seems probable that the whole sensory tract from the posterior columns to the peripheral

nerves is involved. A few cases with ataxia, loss of position sense and Rombergism simulate tabes dorsalis.

Optic atrophy is the most disabling single lesion found in the group. Over 60% of the men were affected at some time during their internment. At present about 6% of the whole series have defective vision constituting a severe disability (vision 20/200 or less). The incidence of optic atrophy could not be definitely related to the non-neurological signs and symptoms of avitaminosis in this series, but it was associated with absent tendon reflexes, defective vibratory sense and Rombergism more than twice as often as could be accounted for by chance alone. From this it is suggested that the causes of the optic atrophy and of the other neurological lesions may be related but are not necessarily the same.

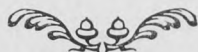
The ultimate correlation of all signs and symptoms found in the series showed that the abnormal sweating could not be correlated with any of the others. Symptoms referable to the stomach, gastro-intestinal tract and heart, however, showed a greater correlation among themselves than could be accounted for by chance. It is inferred from this that these symptoms may arise from a common vagal lesion.

It may be considered that in the group as a whole there are three separate neurological lesions: (1) of the sympathetic system; (2) of the vagus; (3) of the optic nerves and the afferent tract (peripheral nerves, posterior root and posterior column). These separate lesions all appear to be due to B complex deficiency, but there is no evidence as to which factor of the complex is responsible for which lesion.

Dr. D. C. Brereton presented a case showing clinical evidence of a degenerative lesion in the posterior columns of the cord, and Dr. S. Kobrinsky showed the case of Beri-beri heart which had been mentioned in Dr. Adamson's paper.

The meeting was rounded out by two papers largely designed for the enlightenment of the more junior members of the medical staff. Dr. A. N. Sommerville of the Pensions Medical Staff spoke on "Pensions Procedure" and Dr. V. J. McKenty discussed "Disability Evaluation." Both talks produced considerable interested discussion.

D. B. S.



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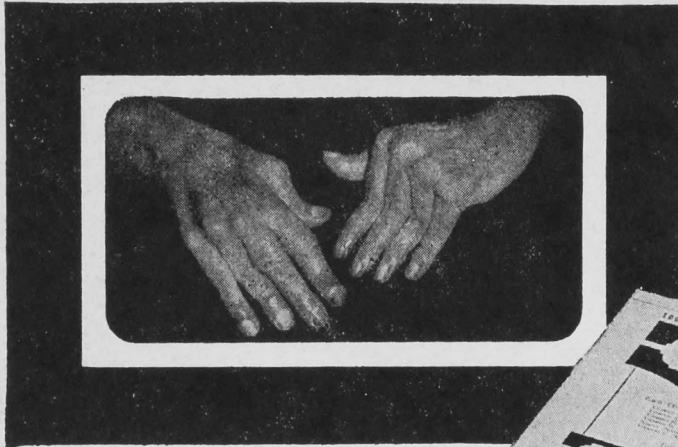
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DOSE: Up to six capsules daily. Complete dosage table on request.



Charles E. Frosst & Co.
MONTREAL CANADA

Association Page

Premarital Blood Test

An Act to amend the Marriage Act was assented to by the Legislative Assembly of Manitoba on April 13, 1946. The amendment requires the production by each of the parties to the intending marriage of a certificate completed and signed by a legally qualified medical practitioner indicating that a sample of blood had been taken not more than thirty days previously. This certificate is to be handed to the person performing the ceremony.

The legally qualified medical practitioner before giving the certificate is required by the Act to:

"(1) Take from the applicant a sample of blood.

(2) Send the blood sample to a laboratory of the Laboratory Services of Department of Health and Public Welfare and request that a serological test for Syphilis be made in respect thereof; and,

(3) On receipt from the Laboratory of the report on the test made, communicate the contents of the report to the applicant by personally handing to him a written statement setting forth the contents of the report, and explaining the statements to him as may be necessary or required."

Penalties are provided for false certification.

Provision is made for waiver of certificate by the Minister of Health and Public Welfare on written application and subject to the Regulations. The Act became effective on October 1, 1946. The test is compulsory but no facilities were set up by the Manitoba Government whereby the test and certificates would be provided without cost to the contracting parties. There is no mention of fee which would recompense the doctor for taking the blood, accepting the responsibility of signing two certificates, and of seeing the applicant on a second occasion when he personally handed him the written statement in the form prescribed.

The question of suitable fee was discussed by the Executive of the Manitoba Medical Association in October when the recommendation was made that the fee be \$5.00. Whether this fee was actually charged or was used as a guide as are those of the Schedule of Minimum Fees is difficult to ascertain—one hears that often it was "two-for-five." In any event, the proposed fee was the subject of discussion in newspapers, among medical men engaged in general practice and those in special fields, in the City Clinics and the Local Health Units, among those who make and those who watch legislation.

The matter was recently reviewed by the Executive of the Manitoba Medical Association and, with the definite assurance that changes in the Act are contemplated at the coming session

of the Legislature whereby the blood specimen may be taken, the medical practitioner may sign the certificates required, and may mail a negative report to each person, thus obviating the return trip and the "personal handing," it was agreed to recommend that the fee be \$3.00.

Dr. Digby Wheeler has returned from the meeting of the Inter-American Congress of Radiology, held in Havana, Cuba, November 17th to 25th. 650 members were registered, the large majority from Central and South America. Dr. Wheeler presented a paper to the meeting at the request of the American College of Radiology. Atomic Energy and the possible application to Medical Science was the subject of a symposium.

A recent meeting of the Radiological Society of North America, held at Chicago, was attended by Dr. R. A. Macpherson, Dr. H. M. Edmison, Dr. M. K. Kiernan and Dr. J. W. Simpson.

Local Programme Committee for Annual Meeting of C.M.A. at Winnipeg in June, 1947

There was a good attendance of the Chairman and Secretary of the various sections on November 21st when discussion of the Scientific Programme took place. Subsequently, on December 5th, programme suggestions were made by the various sections and a tentative programme was drawn up for forwarding to the Central Programme Committee.

Rockefeller Foundation Report

"The Report of Rockefeller Foundation on Personnel Requirements of the Health Services Act of the Province of Manitoba" was released on December 3, 1946.

It is noted that an amendment has been made on Page 8 where a footnote has been added referring to the number of Psychiatric personnel.

The Report is being studied by individuals and groups representing organized medicine.

D.V.A. Schedule of Fees

On November 28, 1946, a booklet containing the Schedule of Fees for Medical Service was sent from Ottawa to all Licensed Medical Practitioners in Canada.

If you have not received a copy of the Instructions and the Summary of Treatment Regulations or the Schedule of Fees, apply to the District Medical Officer, Dept. of Veterans Affairs, Commercial Bldg., Winnipeg.

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Winnipeg Medical Society—Notice Board

W. F. Tisdale, *President*

Cecil W. Clark, *Vice-President*

Next Meeting

Friday, Jan. 17th

C. K. Bleeks, *Treasurer*

R. A. MacPherson, *Secretary*

meeting of the Council of the Winnipeg Medical Society was held in the Club Rooms, per 11th.

ing to the proximity of the third Friday to has, and especially owing to the fact that the opportunity of having a distinguished Dr. R. A. Peters, a professor of biochemistry Oxford university, to speak to us, we to move the date of our regular meeting ne week and hold it December 13th.

following new members were admitted: Boris Black, D. Gordon Coghlin, S. H. O. on, Wm. F. D. Evelyn, Wallace Grant, M. farland, N. B. Maclean, D. M. Mitchell, E path, G. A. Waugh.

following applications for membership approved: Doctors J. L. Asselstine, F. R. M. J. Furman, Joseph Graf, Gordon A. one, Arthur H. Povah, Robert M. Ramsay.

arding the formation of a trust fund, this was introduced by the Chairman and dis- at some length. It was agreed that this be brought up at a general meeting and a ttee appointed to investigate and report on sibilities.

etter of general interest was read from Dr. Cameron re Freidman Test Committee. Ap- ly the fund for these tests is running low e University will be unable to continue ing the service under present conditions. a matter of very great interest to all prac- ts, and we have taken immediate steps to a report on the situation and if possible, osal for its solution.



are naturally curious to know in whose lies the conduct of your Society affairs and ose now to enlighten you upon this matter. of all, of course, is our President, Walter —Walter Felix Tisdale to be exact. With for a middle name I have often wondered e has not been nick-named "Happy." It be in modern parlance, a "natural." Our resident is Cecil Clark who, among other achievements overseas had the honor, or re, or duty, or pain, of inflicting upon our George Evoy his solitary wound. Ralph (lover) McPherson looks after secretarial while the money-bags are held by Cherry s. It's worth \$5.00 to see how pleasantly y gives a receipt so, if you have not yet got

yours, stimulate him by paying your dues at the next meeting.

The two past presidents—Alec Goodwin and Pat McNulty—stand by as Elder Statesmen to give the benefit of their experience. The remaining elected members are the trustees of whom there are three. The senior member of this trinity is Anna Wilson whose gracious, smiling personality radiates good cheer as she handles the tea cups at the after-meeting snack. Her chief assistant is Donald Huggins and the junior member is Fred Abbott.

I am satisfied that Dr. Huggins will carry on the Wilson tradition in the Wilson fashion but a hae ma doots about Fred. He's probably safe enough when it comes to tea and coffee but beware of him if he should coax you to take something out of a bottle decorated with a black quadruped. Believe me it's "pisen" and I know whereof I speak. Here is the evidence.

Some years ago Fred invited me to spend a week-end at his summer home which, in case you don't know, is a palatial residence covering the larger part of a fair-sized island. When we arrived the sun was high and hot. The drinking water was unpleasantly warm so Fred suggested (oh so subtle and cunning he is!) that we slake our thirst with a fluid called Black Mule. Fred and Earl Stewart drank with such gusto and pleasure that I followed their example but alas, with far different results. I did not expect much of the taste nor was I disappointed but, if unlike St. John's little book in one regard ("in the mouth it was sweet") it was too much like it in the other ("in the belly it was bitter"). It had the most extraordinary pharmacological action for it not only stimulated my oxyntic cells to tremendous, preternatural activity but altered their secretion from weak hydrochloric acid to sulphuric acid of the utmost concentration. Or so it felt. Likewise it felt as if a wilderness of mules were cavorting about in my innards. Some time later when I had recovered consciousness and was able to speak, my stomach gave evidence of its personal disgust by violent, body-and-soul shaking emesis. Those of you who follow the fortunes of Li'l Abner can, if you wish, enjoy (?) the effects of Kickapoo Joy Juice by imbibing this essence of Black Mule but, unless you have the stomachs of "Hairless" and "Indian Joe" you will suffer. It is only fair to add that Fred's distress was as great as my own because being an ideal host, he regretted my

gastronomic frailty. But being of a rugged constitution I quickly overcame the effects of the experience and the rest of the holiday was very pleasant. But in all fairness to other innocents I must repeat my warning—Beware of Fred when you see him in the company of Black Mules.

To return to our mutttons, as our French friends would say, there are a number of committees. The Membership Committee is headed by Dr. Lebbetter with G. Stevens and Sam Kobrinsky to assist him. Judging by the number of applications they bring in, they appear to be what Dr. Curran calls "sharp cookies." (I like that expression.) The programme Committee is Dr. Tanner to whom I take this opportunity of addressing myself thus: Dear Bob, Please see that I get all the papers for the Review.

Medico-Historical

Edward Gibbon

On January 16th, 1794, died Edward Gibbon and hereunder is given Lord Sheffield's narration of his last illness and death. It is the concluding portion of Gibbon's *Autobiography*, a book "without which no library can be called complete." High in the same category is his magnum opus, "The Decline and Fall of the Roman Empire"—"the most gorgeously written history in the language." It is a most "enriching" work to read for it enriches both the knowledge and the vocabulary of the reader. No one can read it without becoming curious about the author—about his life and how he went about his work. The "Autobiography" answers these questions.

Edward Gibbon was born of an ancient and well-to-do family at Putney on April 27th, 1737. He was the oldest and only surviving child of his father's first marriage. He himself was so delicate that he was not expected to reach maturity. He could not attend school but being an omnivorous reader he gathered a vast and varied stock of learning. When he was 15 his health had improved considerably and he was entered at Magdalen College, Oxford, as a gentleman commoner. In his own words he "arrived there with a stock of erudition that might have puzzled a doctor, and a degree of ignorance of which a school boy would have been ashamed."

At that time students at Oxford had little supervision and Gibbon, left to his own devices, found himself "betrayed into some improprieties of conduct"—"costly and dangerous follies." Because of these, and for other excellent reasons Gibbon was removed from Oxford after a stay of 14 months and despatched in semi-exile to Lausanne. There he fell in love with a maiden "whose wit, beauty and erudition were the theme of universal applause." He saw and loved. Some-

Ross Cooper who, when you think of it, looks a bit like a lawyer, is the Legislative Committee, Sol Kobrinsky, who has served us most faithfully in many capacities over many years, is the Public Health Committee.

Three others complete this roster of the Executive Council. Ross Mitchell represents us on the Library Committee, Bill Boyd (not the pathologist) on the Executive Committee of the Association and Dr. Skaling on the Council of Social Agencies.

These are the men and women, who, following the tradition of our Society, will for this session consider their time our time and will, as in the past, hold our affairs and our interest first in their thoughts. But their success depends upon our co-operation so let us give it in full measure.

time later he proposed to her but, being even then excessively corpulent, he found that he could not, of himself, rise from his knees and had to be assisted. The maiden was willing but not the parent and Gibbon "sighed as a lover but obeyed as a son."

He returned to England in 1758 and spent two years in "military servitude." Then he set out upon the "Grand Tour" on which he visited Paris, Lausanne again, and Italy. Amid its ruins the Grandeur that was Rome arose before him. "It was at Rome on the 15th of October, 1764, as I sat musing amidst the ruins of the capitol, while barefooted friars were singing vespers in the temple of Jupiter that the idea of writing the decline and fall of the city first started to mind." The task then begun continued for 24 years and raised Gibbon to pre-eminence among the historians of his own and past times. He had a pagan sympathy for, and understanding of, the Romans, and surprised "people who had been brought up to believe that the chief sport of Roman emperors was making martyrs of Christians." His prejudices, never many or great, have been corrected in the notes of later editions.

A year after the completion of his history, in 1789, Gibbon began the writing of his *Autobiography*. It was never completed but was edited and published by his friend, Lord Sheffield, who is the writer of what follows:

Gibbon's Last Illness

From Gibbon to Lord Sheffield

Nov. 11, 1793.

"I must at length withdraw the veil before my state of health, though the naked truth may alarm you more than a fit of the gout. Have you never observed, through my inexpressibles, a large prominence which, as it was not at all painful, and very little troublesome, I had strangely

neglected for many years? But since my departure from Sheffield Place it has increased (most stupendously), is increasing, and ought to be diminished. Yesterday I sent for Farquhar, who is allowed to be a very skilful surgeon. After viewing and palpating, he very seriously desired to call in assistance, and has examined it again today with Mr. Cline, a surgeon, as he says, of the first eminence. They both pronounce it a hydrocele (a collection of water), which must be let out by the operation of tapping; but, from its magnitude and long neglect, they think it a most extraordinary case, and wish to have another surgeon, Dr. Baillie, present. If the business should go off smoothly, I shall be delivered from my burthen (it is almost as big as a small child), and walk about in four or five days with a truss. But the medical gentlemen, who never speak quite plain, insinuate to me the possibility of an inflammation, of fever, etc. I am not appalled at the thoughts of the operation, which is fixed for Wednesday next, twelve o'clock; but it has occurred to me that you might wish to be present, before and afterwards, till the crisis was past; and to give you that opportunity I shall solicit a delay till Thursday or even Friday. Adieu."

Lord Sheffield's Narrative

When he returned to England in 1787, I was greatly alarmed by a prodigious increase, which I always conceived to proceed from a rupture. I did not understand why he, who had talked with me on every other subject relative to himself and his affairs without reserve, should never in any shape hint at a malady so troublesome; but on speaking to his valet de chambre, he told me Mr. Gibbon could not hear the least allusion to that subject, and never would suffer him to notice it. I consulted some medical persons, who, with me supposing it to be a rupture, were of opinion that nothing could be done, and said that he surely must have had advice, and of course had taken all necessary precaution. He now talked freely with me about his disorder, which, he said, began in the year 1761; that he then consulted Mr. Hawkins the surgeon, who did not decide whether it was the beginning of a rupture, or a hydrocele; but he desired to see Mr. Gibbon again when he came to town. Mr. Gibbon, not feeling any pain, nor suffering any inconvenience, as he said, never returned to Mr. Hawkins; and although the disorder continued to increase gradually, and of late years very much indeed, he never mentioned it to any person, however incredible it may appear, from 1761 to November, 1793. I told him that I had always supposed there was no doubt of its being a rupture; his answer was, that he never thought so, and that he and the surgeons who attended him were of opinion that it was a hydrocele. It is now certain that it was originally a rupture,

and that a hydrocele had lately taken place in the same part; and it is remarkable that his legs, which had been swelled about the ankle, particularly one of them, since he had the erysipelas in 1790, recovered their former shape as soon as the water appeared in another part, which did not happen till between the time he left Sheffield Place, in the beginning of October, and his arrival at Althorp, towards the latter end of that month. On the Thursday following the date of his last letter Mr. Gibbon was tapped for the first time; four quarts of a transparent watery fluid were discharged by that operation. Neither inflammation nor fever ensued; the tumor was diminished to nearly half its size; the remaining part was a soft irregular mass. I had been with him two days before, and I continued with him above a week after the first tapping, during which time he enjoyed his usual spirits; and the three medical gentlemen who attended him will recollect his pleasantry, even during the operation. He was abroad again in a few days, but, the water evidently collecting very fast, it was agreed that a second puncture should be made a fortnight after the first. Knowing that I should be wanted at a meeting in the country, he pressed me to attend it, and promised that soon after the second operation was performed he would follow me to Sheffield Place. . . .

By his own desire I did not follow him till Thursday the 9th of January, 1794. I then found him far from well. The tumor more distended than before, inflamed, and ulcerated in several places. Remedies were applied to abate the inflammation; but it was not thought proper to puncture the tumor, for the third time, till Monday the 13th of January, when no less than six quarts of fluid were discharged. He seemed much relieved by the evacuation. His spirits continued good. . . .

I had not any apprehension that his life was in danger, although I began to fear that he might not be restored to a comfortable state, and that motion would be very troublesome to him; but he talked of a radical cure. He said that it was fortunate the disorder had shown itself while he was in England, where he might procure the best assistance; and if a radical cure could not be obtained before his return to Lausanne, there was an able surgeon at Geneva, who could come to tap him when it should be necessary.

On Tuesday the 14th, when the risk of inflammation and fever from the last operation was supposed to be passed, as the medical gentlemen who attended him expressed no fears for his life, I went that afternoon part of the way to Sussex, and the following day reached Sheffield Place. The next morning, the 16th, I received by the post

a good account of Mr. Gibbon, which mentioned also that he hourly gained strength. In the evening came a letter by express, dated noon that day, which acquainted me that Mr. Gibbon had had a violent attack the preceding night, and that it was not probable he could live till I came to him. I reached his lodgings in St. James's Street about midnight, and learned that my friend had expired a quarter before one o'clock that day, the 16th of January, 1794.

Plague in the 6th Century

Ethiopia and Egypt have been stigmatised in every age as the original source and seminary of the plague. In a damp, hot, stagnating air, this African fever is generated from the putrefaction of animal substances and especially from the swarms of locusts, not less destructive to mankind in their death than in their lives. The fatal disease which depopulated the earth in the time of Justinian and his successors first appeared in the neighbourhood of Pelusium, between the Serbonian bog and the eastern channel of the Nile. From thence, tracing as it were a double path, it spread to the East, over Syria, Persia, and the Indies, and penetrated to the West, along the coast of Africa and over the continent of Europe. In the spring of the second year Constantinople, during three or four months, was visited by the pestilence; and Procopius, who observed its progress and symptoms with the eyes of a physician, has emulated the skill and diligence of Thucydides in the description of the plague of Athens. The infection was sometimes announced by the visions of a distempered fancy, and the victim despaired as soon as he had heard the menace and felt the stroke of an invisible spectre. But the greater number, in their beds, in the streets, in their usual occupation, were surprised by a slight fever; so slight, indeed, that neither the pulse nor the color of the patient gave any signs of the approaching danger. The same, the next, or the succeeding day, it was declared by the swelling of the glands, particularly those of the groin, of the armpits, and under the ear; and when these buboes or tumors were opened, they were found to contain a coal, or black substance, of the size of a lentil. If they came to a just swelling and suppuration, the patient was saved by this kind and natural discharge of the morbid humour; but if they continued hard and dry, a mortification quickly ensued, and the fifth day was commonly the term of his life. The fever was often accompanied with lethargy or delirium; the bodies of the sick were covered with black pustules or carbuncles, the symptoms of immediate death; and in the constitutions too feeble to produce an eruption, the vomiting of blood was followed by a mortification of the bowels. To

pregnant women the plague was generally mortal; yet one infant was drawn alive from his dead mother, and three mothers survived the loss of their infected foetus. Youth was the most perilous season, and the female sex was less susceptible than the male; but every rank and profession was attacked with indiscriminate rage, and many of those who escaped were deprived of the use of their speech, without being secure from a return of the disorder. The physicians of Constantinople were zealous and skilful; but their art was baffled by the various symptoms and pertinacious vehemence of the disease: the same remedies were productive of contrary effects, and the evenhandedly capriciously disappointed their prognostics of death or recovery. The order of funerals and the righting of sepulchres were confounded; those who were left without friends or servants lay unburied in the streets, or in their desolate houses; and no magistrate was authorized to collect the promiscuous heaps of dead bodies, to transport them by land or water, and to inter them in deep pits beyond the precincts of the city. Their own danger and the prospect of public distress awakened some remorse in the minds of the most vicious of mankind: the confidence of health again revived their passions and habits; but philosophy must disdain the observation of Procopius, that the lives of such men were guarded by the peculiar favour of fortune or Providence. He forgot, or perhaps he secretly recollected, that the plague had touched the person of Justinian himself; but the abstemious diet of the emperor may suggest, as in the case of Socrates, a more rational and honorable cause for his recovery. During his sickness the public consternation was expressed in the habits of the citizens; and their idleness and despondence occasioned a general scarcity in the capital of the East.

Contagion is the inseparable symptom of the plague; which, by mutual respiration, is transfused from the infected persons to the lungs and stomach of those who approach them. While philosophers believe and tremble, it is singular that the existence of a real danger should have been denied by a people most prone to vain and imaginary terrors. Yet the fellow-citizens of Procopius were satisfied by some short and partial experience, that the infection could not be gained by the closest conversation; and this persuasion might support the assiduity of friends or physicians in the care of the sick, whom inhuman prudence would have condemned to solitude and despair. But the fatal security, like the predestination of the Turks, must have aided the progress of the contagion; and those salutary precautions to which Europe is indebted for her safety were unknown to the government of Justinian. No restraints were imposed on the free and frequent intercourse of the

cal Roman provinces: from Persia to France the contagions were mingled and infected by wars and migrations; and the pestilential odor which lurks in a bale of cotton was imported, by the abuse of trade, into the most distant regions. The mode of its propagation is explained by the remark of Procopius himself, that it always spread from the sea-coast to the inland country: the most unrequered islands and mountains were successively visited; the places which had escaped the fury of its first passage were alone exposed to the contagion of the ensuing year. The winds might diffuse that subtle venom; but unless the atmosphere be previously disposed for its reception, the plague would soon expire in the cold or temperate climates of the earth. Such was the universal corruption of the air, that the pestilence which burst forth in the fifteenth year of Justinian was not checked or alleviated by any difference of the seasons. In time its first malignity was abated

and dispersed; the disease alternately languished and revived; but it was not till the end of a calamitous period of fifty-two years that mankind recovered their health, or the air resumed its pure and salubrious quality. No facts have been preserved to sustain an account, or even a conjecture, of the numbers that perished in this extraordinary mortality. I only find that, during three months, five and at length ten thousand persons died each day at Constantinople; that many cities of the East were left vacant; and that in several districts of Italy the harvest and the vintage withered on the ground. The triple scourge of war, pestilence, and famine afflicted the subjects of Justinian; and his reign is disgraced by a visible decrease of the human species, which has never been repaired in some of the fairest countries of the globe.

Gibbon: Decline and Fall of the Roman Empire.

Medical Happenings for January

Tuesday, 7—

Luncheon, Winnipeg General Hospital,
12:30 p.m.

Wednesday, 8—

Tumor Clinic, Winnipeg General Hospital,
9:00 a.m.

Thursday, 9—

Ward Rounds, Children's Hospital, 11:00 a.m.

Thursday, 9—

Luncheon, St. Boniface Hospital, 12:30 p.m.

Friday, 10—

Tumor Clinic, St. Boniface Hospital, 10:00 a.m.

Friday, 10—

Luncheon, Grace Hospital, 12:30 p.m.

Wednesday, 15—

Tumor Clinic, Winnipeg General Hospital,
9:00 a.m.

Thursday, 16—

Ward Rounds, Children's Hospital, 11:00 a.m.

Thursday, 16—

Luncheon, Winnipeg General Hospital,
12:30 p.m.

Friday, 17—

Tumor Clinic, St. Boniface Hospital, 10:00 a.m.

Friday, 17—

Meeting, Winnipeg Medical Society, 8:15 p.m.,
Medical College.

Tuesday, 21—

Luncheon, St. Joseph's Hospital, 12:30 p.m.

Wednesday, 22—

Tumor Clinic, Winnipeg General Hospital,
9:00 a.m.

Thursday, 23—

Ward Rounds, Children's Hospital, 11:00 a.m.

Thursday, 23—

Luncheon, St. Boniface Hospital, 12:30 p.m.

Friday, 24—

Tumor Clinic, St. Boniface Hospital, 10:00 a.m.

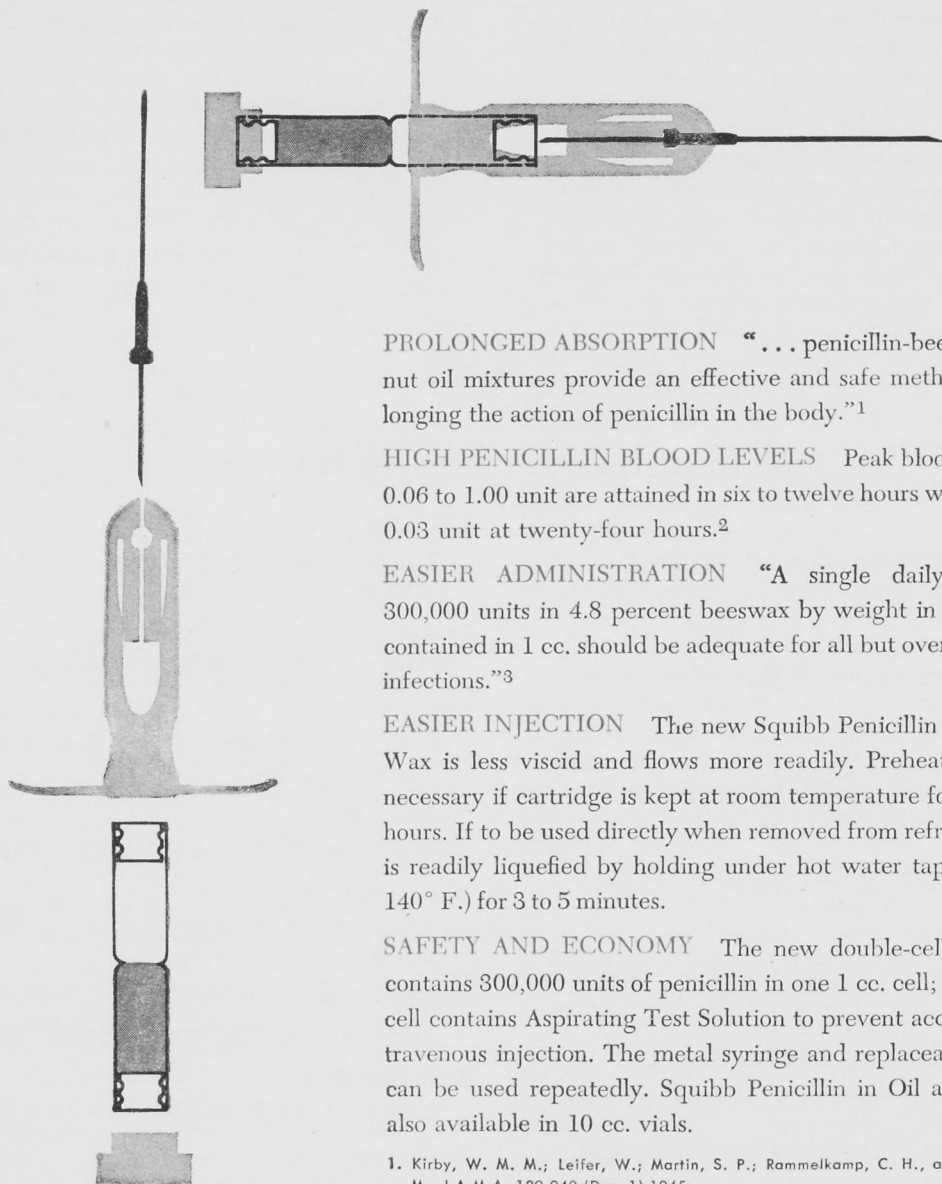
Tuesday, 28—

Luncheon, Victoria Hospital, 12:30 p.m.

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1. Kirby, W. M. M.; Leifer, W.; Martin, S. P.; Rammelkamp, C. H., and Kinsman, J. M.: J.A.M.A. 129:940 (Dec. 1) 1945.

2. Nichols, D. R., and Haunz, E. A.: Proc. Staff Meet. Mayo Clinic 20:403 (Oct. 31) 1945.

3. Romansky, M. J., and Rittman, G. E.: New England J. Med. 233:577 (Nov. 15) 1945.

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TORONTO

Editorial

J. C. Hossack, M.D., C.M. (Man.), Editor

Plans for the Future

We wish you all a very Happy and Prosperous New Year. More than that, we shall try to help you towards it by improving the Review. From now on there will be each month an article and abstracts on Gynecology and Obstetrics. There will be similar attention paid to Pediatrics and Tuberculosis. Those responsible are Dr. R. Lyons who is a graduate of the University of London, a member of the College of Obstetrics Gynecology, a member also of the Faculty of Medicine and of the staff of the Winnipeg General Hospital. Dr. Joseph Graf, assisted by Dr. Murray McLandress and S. Israels will look after paediatric matters. Dr. Graf studied in the cradle of modern medicine the Universities of Northern Italy—and holds a diploma in Pediatrics from the University of Modena. (Modena, it will be recalled, was the home town of Mary, Queen Consort to James II. Likewise it was the place where Antony besieged Decimus Brutus in 43 B.C.). Dr. Kenneth Johnson of the St. Boniface Sanatorium, will have responsibility for the abstracts and papers on tuberculosis. I hope that we shall shortly have other departments similarly organized.

Now all of these new workers are going to work hard to help you. They are energetic and enthusiastic. In other words—those of a recent lady graduate—they are “sharp cookies” (is that right Dr. Curran?) They will carry a not inconsiderable burden however much you choose to lighten it but will you please try to lighten it by sending in reports of your own experiences and the results of your own reading and writing?

Premarital Tests

Dr. Cadham informs me that at his laboratory no samples of blood are taken for examination. Dr. Macfarland, in his page has a note on the subject of premarital blood tests. Else where you will see a letter from Dr. Gilbert Lansdown. I received it sometime ago but feel that it will be read with greater profit now that all practitioners have had experience with the new regulation.

Others have propounded similar interesting questions. What about the possible instance of both parties having positive reactions? What about the person who has signs of lues but is Wassermann negative? What about those who have or have had recently positive smears? There are many questions which should be discussed at meetings of district societies especially in view of the fact that changes in the act are being contemplated.

We Get Around

Every now and then we hear of the Review penetrating into some remote corner of the earth and occasionally we learn with pleasure that we are not un-noticed in Olympian circles. The latest evidence of how we get around is furnished by Dr. Digby Wheeler who, while in Washington, D.C., noticed our name on the editorial page of the eminent Times-Herald news-sheet of that City. The portion quoted was the selection from Ecclesiastes. We are naturally gratified to learn that our Review is read in such cultured and sophisticated regions; and, I am sure, the Washingtonians will be much relieved to know that we Manitobans are a God-fearing people who read our Bibles.

Flies in the Ointment

There are flies in the ointment of Mr. Whitley. This is unfortunate because, you will remember, “a fly in the ointment of the apothecary (or of Mr. Whitley) causeth it to send forth a stinking savour.” One particularly large fly is furnished by subscribers who change their addresses without notifying the office. Usually the first we know of the change is when the subscriber indignantly demands to know why he is not getting his Review. Now it is well to be told by subscribers that they miss our journal. Obviously that means they think it is good and in all due modesty we may say that it is good. But it is not good enough to re-address itself, or to put itself into the mail box, or to find its way of itself into the hands of its proper owner. So will any of you who mean to change your address please keep in mind the little fellow's physical limitations and notify the office of the change? Then we shall all be happy in the assurance that it will reach you regularly and promptly. Also, it will diminish by one the fly population of Mr. Whitley's ointment.

Letter to The Editor

Dear Dr. Hossack:

I expect you have seen this enclosure on the compulsory premarital blood test. Several people (two of them women), all of whom strongly approve of the test, have called my attention to an ambiguity in the last two paragraphs of the advertisement, which might provide a loophole. If the certificate given to the person solemnizing the marriage does not state definitely that the test

was negative, but leaves it open, is it not possible that one of the parties to the marriage might state that the certificate given to him or her was negative when it was positive for the disease? The certificate given to the person performing the ceremony does apparently only certify that the test has been made, and leaves the interpretation of that certificate to the person performing the ceremony.

I think attention should be called to this ambiguity and have it cleared up, and the second certificate make it clear that the test was negative.

I am very glad to see that the hush-hush attitude towards Venereal Disease is disappearing and its disappearance will help to prevent our civilization (such as it is) changing completely into syphilization.

Yours sincerely,

Gilbert H. Lansdown.

Obituary

Dr. Gerald S. Williams

Dr. Gerald S. Williams, veteran of the two world wars, and for many years superintendent of the Children's Hospital, Winnipeg, died at Deer Lodge Hospital on December 2, aged 57.

Born in Winnipeg he was educated in the local schools and graduated from Manitoba Medical College in 1913. During the First World War he served overseas with the R.A.M.C., transferring later to the R.C.A.M.C. At the end of the war he returned to Winnipeg, served with the soldiers civil re-establishment board and was also in general practice. In 1923 he became superintendent of the Children's Hospital, and developed a talent for administration. He was a director of the Manitoba Hospital Association and a Fellow of the American College of Hospital Administrators.

On the outbreak of the Second World War he obtained leave of absence from the hospital from 1940 to 1944. He was medical officer of the 10th Signal Corps, served overseas and obtained the rank of lieutenant-colonel.

Dr. Williams was keenly interested in golf and curling. He was a member of the vestry of St. Paul's Anglican Church, Fort Garry.

He is survived by his widow, a daughter and two sons.

Vacancies for Medical Officers

The R.C.A.M.C. has a number of vacancies for junior medical officers. In the post-war Army, and the majority of medical officers will spend the first ten years of their service as unit medical officers or junior medical officers in hospitals. They will be given a year's post-graduate training at Army expense, and those with special qualifications will have an opportunity for a further year's study in such branches as training with Field Medical Units, hospital administration, staff courses, medicine, surgery, anaesthetics, Public Health, Psychiatry. Courses may be obtained in Canada, the U.K., or the U.S. during the year's study leave.

There is an opportunity in the Army for good professional work with modern equipment. Military District No. 10 is operating small hospitals at Churchill and Shilo with good laboratory facilities, X-ray units and surgical equipment. Due to their isolation there will also be a large measure of care for dependents and, in the case of Churchill for the civilian population who have no other medical facilities. Fort Osborne Military Hospital will be a 75-bed hospital with one Major anaesthetist, surgeon and internist on the staff. This hospital will cover the Army, Navy and Air Force needs in the district. There is in addition an establishment for medical officers with the R.C.H.A. at Shilo, and with the Paratroop Training Centre.

The ultimate future for the senior ranks is mainly in administrative appointments, although there are Lieut.-Colonel's postings for surgeons and internists at Ottawa and Toronto.

Normal tour of duty is 2-5 years on a station at the end of which time one's expenses are provided for transfer of family and furniture to a new posting. Annual rates of pay are as follows:

Captain	\$3,360.00
Major	4,260.00
Lieutenant-Colonel	4,860.00
Colonel	6,360.00
Brigadier	8,040.00

The pension scheme is most adequate. It is based on 2 per cent for each year of service in the Army, including War service, and quarter time for N.P.A.M. service. It has an insurance clause after ten years for disability or death, but one is not otherwise eligible for pension until 20 years service except in the case of officers who served during the past War, who may retire after 10 years service.

For particulars consult the District Medical Officer at Fort Osborne Barracks.

Personal Notes and Social News

Mr. and Mrs. Roy W. Richardson are happy to announce the birth of a daughter on December 11th, 1946, at the Winnipeg General Hospital.

Mr. and Mrs. Anaid Servart Mooradian, only daughter of Mr. and Mrs. John H. Mooradian, of Hamilton, Ont., was married on December 20th at the chapel of St. Ignatius church, Winnipeg, to Dr. Matthew Kearns Kiernan, only son of Mrs. Kiernan and the late Matthew Kiernan, of Southey, Sask. Dr. Christina A. Curran attended the bride and Dr. W. G. Newman was best man. Following a reception at the Fort Garry hotel, the couple left for Minneapolis, Chicago and Hamilton. They will reside in Winnipeg.

Mr. and Mrs. W. R. Govan take pleasure in announcing the birth of a daughter, Victoria Elizabeth, on December 20th, 1946, at Grace Hospital.

Dr. I. Lerner (U.M.38) has been made a fellow of the Royal College of Surgeons of Canada at a recent convocation at Ottawa.

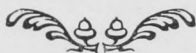
Dr. and Mrs. J. Gilman Barrie wish to announce the birth of a son, Claude Gilman, on December 20th, 1946, at the St. Boniface Hospital.

Dr. and Mrs. H. C. Hutchison are pleased to announce the birth of a son on December 29th, 1946, at Grace Hospital.

Dr. G. S. Baldry, formerly of 616 Medical Arts Building, has moved to Rutland, Mass., where he will reside in future.

Doctors who have agonized over occiput posterior positions at last can know where they come from. As one drives over the Salter Street bridge en route to the Winnipeg General Hospital one sees a sign on Logan Avenue: "R.O.P. Hatchery."

Hi—Ho! and another year is born . . . and may it be a very happy one for you and yours with good health and an abundance of all those things that make living pleasant . . . most people will make (to break) good resolutions . . . not me though, as there are many things I do, that I should not but do because I like to. . . . I cannot resolve not to get swearing mad when someone forgets the deadline date, thereby prolonging the ceremony of "Putting the Baby to Bed" (The Review to Press) causing the issue to be days behind publishing date. . . . I wish that some of my friends would resolve to remember that I take time out each day to guzzle a few cups of good Java . . . to send me Rye in preference to Scotch at festive time, also before and after as there is no closed season for taking a few shots at Joseph E. . . . and—since the Medical Meeting, I will not require any Ancaderma hand lotion (thank you C. S.) until 1957. . . . Creamalin tablets are in short supply as I handed them out very generously after the sumptuous feast given by Mr. Robert Ramsay . . . every sample bottle of Wyeth's B1 elixir should be kept in a steel safety deposit box until the G.L.C.C. replenishes their depleted stocks with better quality—or else . . . please do not phone about typographical errors immediately after lunch when I am picking the steak out of my store teeth, exceptions are Tuesdays and Fridays of course . . . many thanks to S. S. of 901 and friends at the W.C., what a grand combination, the smoke got in my eyes and the dew—let's stop reminiscing.—J. G. W.





*To restore nasal patency
in colds and sinusitis . . .*

Neo-Synephrine decongests promptly . . . clears the nasal airways for greater breathing comfort . . . promotes sinus drainage. Relief lasts for several hours. Virtual freedom from compensatory vasodilatation precludes development of dependency symptoms.

Neo-Synephrine

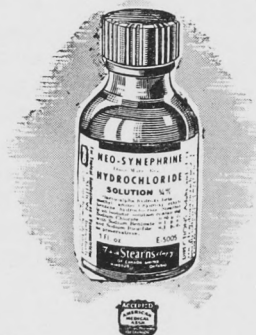
BRAND OF PHENYLEPHRINE

HYDROCHLORIDE

For Nasal Decongestion

THERAPEUTIC APPRAISAL: Prompt, prolonged nasal decongestion without appreciable compensatory reconnection; virtual freedom from local and systemic side effects; sustained effectiveness on repeated use.

INDICATED for symptomatic relief of common colds, sinusitis and allergic rhinitis.



ADMINISTRATION may be by dropper, spray or tampon, using the $\frac{1}{4}\%$ in most cases, the 1% when a stronger solution is indicated.

SUPPLIED as $\frac{1}{4}\%$ and 1% in isotonic saline and $\frac{1}{4}\%$ in an emulsion, bottles of 1 fl. oz.; $\frac{1}{2}\%$ jelly in convenient applicator tubes, $\frac{5}{8}$ oz.

Frederick **Stearns & Company**
of Canada, Ltd.

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Manitoba Medical Service

Sauce for the Gander

A Fantasy

I was in to see Bill the foreman of the Tip Top garage a few days ago because my car hadn't been running very well for a couple of weeks. Bill has looked after the car for a long time, and with his wide experience is able to spot the cause of trouble very easily; he seems to me to be getting educated, though he is not a man of much learning, and I know he is not attending a night school.

Anyway, Bill called over a mechanic, "Now, Jack, I want you to overhaul the Doc's car, it wants looking into, and the Doc thinks it might be in the engine, so make sure it's all right." Four days later Bill telephoned that the car was ready. He assured me that there was nothing the matter with the motor, for they had had it on the bench, and taken it right down. The points on the distributor were worn out and he had replaced them; the only other thing wrong was that the cushions on the back seat were getting very shabby and would soon have to be recovered; I thanked him and asked him what the bill was. \$75.00! You can guess I went up in the air, but I won't repeat what I said. "Wait now, Doc," Bill said, when I stopped for breath, "Two of my best men worked for three days on your car. Do you remember that time in the early spring when I went to see you, because I wasn't feeling so good; and you told me that you'd give me a thorough examination, that's what you called it Doc. There were lots of X-rays, and you pumped my stomach out, and stuck needles into me. It was a great examination Doc; I was

abit disappointed when you told me that I was in a good shape, but was smoking too many cigarettes, and there was a sister, I think you called her, on my back; I could have it taken away anytime for \$10.00. I've been learning a lot lately, Doc."

I think he has, but I'm afraid I'll have to change my repair shop.

T. C. D.

Make Plan B Solvent

Make Plan B solvent. This is heard repeatedly and rightly so. No business can carry on at a continual loss, so rectification is uppermost in the minds of the Manitoba Medical Service staff as well as the doctors. How is this to be done? The first step was to enforce the exclusion of known pre-existing ailments, which exclusion was in the contract, but prior to the writers employment was not used. Since this clause was instigated the amount saved to date is \$43,468.60. Secondly, administrative expense came in for some scrutiny, and while expenses are not at too high a level,

some adjustment is hoped for soon. Thirdly, percentage requirements for Plan B were more strictly enforced, resulting in a slightly heavier swing to Plan A.

It was plain to see that the policy of blank cheque to patients and doctor could not work, yet it was not the expressed wish to curtail services, therefore, the only other step seemed to be to raise the rates on Plan B. Our Board approved raising the rates of Individual Plan B from \$1.50 to \$2.00 and the family from \$3.50 to \$4.00 per month, to become effective October 1st, 1946. Contracts already in force can only be raised on the anniversary date, therefore it will take a year before the full force of this step can be assessed.

Another step taken is the preparation of a short questionnaire which must be completed by all new applicants. This additional work necessitated the employment of additional staff, yet many extra hours have to be spent to keep the daily routine going.

Now all case records are being scrutinized, and to those whose costs for minor services, home calls, etc., are out of proportion to that of the majority, a letter will be sent advising of our aim, and in a mild way, informing the recipient of a desire to co-operate, otherwise we may be forced, on their renewal date, to either revert them to Plan A, the restricted Plan, or refuse to renew said contract.

All these steps were taken to balance the income from Plan B to the services rendered, at the old fee scale. The new fee scale will soon be in force, and will substantially raise the costs for services rendered, yet will the steps already taken offset charges for services on the old fee scale plus this higher scale, or will the demand be to make the Plan solvent irrespective?

Seeing the picture in full from month to month it is not right that doctors should have to accept a 65% payment, that situation must be rectified, but it is not logical to assume the steps being taken will make Plan B solvent against an increased fee scale.

Seeing an average from 5,000 to 6,000 claims a month, in some cases it would appear as though the patient were used to extensive, expensive service, or the doctors "shooting the works." For instance:

Diagnosis: Sprained Wrist—Treatment: 3 office visits, \$11.25; X-ray, chest, \$10.00; Complete Blood, \$5.00; Total Cost, \$26.25.

For minor ailments, instead of seeing their family doctor first, the main thought seems to be, "go through the clinic." The subscriber knows this to be a more costly type of service which under ordinary circumstances he could not afford

himself, but readily uses when he knows someone else has to pay for the service.

Should it not always be kept in mind that the aim of the Manitoba Medical Service is to supply a service which would be just and fair were the patient having to foot the bill himself. Most doctors supply such a service, but not all.

The circular below is sent to certain subscribers, and is self-explanatory. As you will see, there is no threat of cancellation. Frequently a call from the subscriber is the result. In most cases he is much surprised at the cost. Occasionally he asks to see the bills, and criticizes the amount charged for the services rendered; however it is pointed out that a fee scale covers all services, and that it is the multiplicity of attendances rather than individual costs which are responsible for the high total.

"Dear Subscriber:

Manitoba Medical Service is a community experiment, demanded by the public. It includes the doctor rendering the service and the sick receiving such service. Restrictions are kept to a minimum, the main exclusion being that of a known pre-existing ailment. It is intended to furnish the care which people would ordinarily provide for themselves, but without the financial worry. It is based on the average care of normal individuals and families, and includes the occasional serious illness and major operation. It is not intended to include frequent attendances for minor ailments or the demand for extensive and expensive diagnostic investigations, often unnecessary.

Unfortunately, the latter has been quite prevalent, and as a result of these too frequent calls

at the office and demanding visits from doctors to the home, revenue failed to meet the appro doctors' bills by \$94,000.00 in the first five months. It is still the wish to provide as complete a service as possible, but at the same time, succeed, the Plan must be made solvent.

The majority of the public are reasonable in their demands; a minority are receiving excessive services at the cost of the community. The possibilities have to be considered: (1) Raising dues considerably; this would hurt every subscriber. (2) Doctors refusing to provide service at the reduced scale which they have been receiving, and returning to billing their patients. (3) Cancelling those contracts where the cost on minor conditions has been excessive."

My sincere thanks to the majority of the doctors for their patience and co-operation, but unfortunately there are still a few whose "shoulder chip" just will not come off. To these few, to realize only the fullest co-operation by patients and doctor can make such a plan succeed. I would also like to thank the Board of Trustees and various Committees for much kindness, assistance and understanding.

In closing, should any doctor read this, and know of any vacant office space, please contact us as one gets tired of having to climb over desks and files to move around. Dr. Moorhead would like to have a nice quiet private office, but not a large one, more, two employees, a desk and two tables. He invaded his sanctum, and while he doesn't mind, I am sure he is wondering what the next move will be, though I can assure him he'll never find his desk outside in the hallway.

A. G. Richardson

Urology Award

The American Urological Association offers an annual award "not to exceed \$500" for an essay (or essays) on the result of some clinical or laboratory research in Urology. Competition shall be limited to urologists who have been in such specific practice for not more than five years and to residents in urology in recognized hospitals.

For full particulars write the Secretary, Dr. Thomas D. Moore, 899 Madison Avenue, Memphis, Tennessee. Essays must be in his hands before May 1, 1947.

The selected essay (or essays) will appear on the programme of the forthcoming meeting of the American Urological Association, to be held at the Hotel Statler, Buffalo, New York, June 30-July 3, 1947.

Deadline

May 1st, 1947, is the deadline for entering the \$34,000 prize art contest on the special subject "Courage and Devotion Beyond the Call of Duty" (on the part of physicians in war and in peace). This contest is open to all M.D.'s in the Western Hemisphere. The exhibition will take place in conjunction with the A.M.A. Centennial Session at Atlantic City, June 9-13th, 1947. For complete information, write or wire now to Francis Redewill, M.D., Secretary, American Physicians' Art Association, Flood Building, San Francisco, California, or to the sponsor, Mead Johnson Company, Evansville 21, Ind., U.S.A.

Department of Health and Public Welfare

Comparisons Communicable Diseases — Manitoba (Whites and Indians)

DISEASES	1946		1945		TOTALS	
	Nov. 3 to Nov. 30	Oct. 6 to Nov. 2	Nov. 4 to Dec. 1	Oct. 7 to Nov. 3	Jan. 1 to Nov. 30, '46	Jan. 1 to Dec. 1, '45
Anterior Poliomyelitis	1	6	—	4	49	20
Diphtheria	161	164	277	200	1,309	2,185
Diphtheria Carriers	13	20	22	16	227	262
Dysentery—Amoebic	9	4	1	1	45	34
Dysentery—Bacillary	—	—	—	6	1	1
Erysipelas	2	2	7	1	62	47
Encephalitis	—	—	—	—	5	8
Influenza	6	3	8	10	196	177
Measles	81	113	6	10	1,925	495
Measles—German	3	1	2	1	26	38
Meningococcal Meningitis	—	1	2	2	19	15
Mumps	112	93	82	64	2,208	1,408
Ophthalmia Neonatorum	—	—	—	—	—	—
Pneumonia—Lobar	6	13	9	15	166	132
Scarlet Fever	—	—	—	—	2	1
Scarlet Fever	40	46	53	91	570	708
Septic Sore Throat	1	1	5	6	35	33
Smallpox	—	—	—	—	—	—
Tetanus	—	—	—	—	1	3
Rachoma	—	—	—	—	2	5
Tuberculosis	87	106	133	77	979	825
Typhoid Fever	1	2	1	2	21	41
Typhoid Paratyphoid	—	—	—	—	3	6
Typhoid Carriers	—	1	—	—	3	3
Undulant Fever	1	—	2	—	18	13
Whooping Cough	51	34	25	29	369	317
Gonorrhoea	153	171	228	229	2,225	2,104
Syphilis	69	66	55	55	651	559
Diarrhoea and Enteritis, under 1 yr.	7	22	4	8	231	26

Four-week Period Report—November 3rd to November 30th,
1946

DISEASES	Manitoba	Ontario	Saskatchewan	Minnesota
(White Cases Only)				
Approximate population.	736,000	3,825,000	906,000	2,972,000
Anterior Poliomyelitis	1	34	3	78
Diphtheria	161	1409	122	—
Diarrhoea & Enteritis (under 1 yr.)	7	—	—	—
Diphtheria	13	45	11	51
Diphtheria Carrier	9	—	—	—
Dysentery—Amoebic	—	13	—	11
Erysipelas	2	4	1	—
Influenza	6	13	1	—
Infectious Jaundice	—	33	—	—
Measles	81	313	1240	22
Measles—German	3	50	3	—
Meningococcal Meningitis	—	7	2	7
Mumps	112	1116	321	—
Pneumonia, Lobar	6	—	—	—
Scarlet Fever	40	379	5	100
Septic Sore Throat	1	1	—	—
Tuberculosis	87	220	40	1
Typhoid Fever	1	1	—	—
Typhoid Para-Typhoid	—	1	—	—
Undulant Fever	1	2	—	2
Whooping Cough	51	335	32	36
Gonorrhoea	153	425	—	—
Syphilis	69	405	—	—

DEATHS FROM COMMUNICABLE DISEASES

For the Month of October, 1946

Urban—Cancer, 46; Influenza, 1; Pneumonia, Lobar, 4; Pneumonia (other forms), 2; Syphilis, 1; Tuberculosis, 4; Disease of Pharynx and Tonsils, 2; Meningococcal Meningitis, 1; Septicemia and Pyemia, 2; Dis. due to Spirochetes, 1; Diarrhoea and Enteritis (under 2 years), 5. Other deaths under 1 year, 16. Other deaths over 1 year, 177. Stillbirths, 14.

Rural—Cancer, 26; Erysipelas, 1; Influenza, 3; Pneumonia, Lobar, 2; Pneumonia (other forms), 6; Syphilis, 1; Tuberculosis, 4; Dysentery, 1; Septicemia and Pyemia, 1; Dis. due to Spirochetes, 1; Hodgkin's Disease, 1; Diarrhoea and Enteritis (under 2 years), 12. Other deaths under 1 year, 23. Other deaths over 1 year, 161. Stillbirths, 10.

Indians—Cancer, 1; Influenza, 1; Pneumonia, Lobar, 1; Pneumonia (other forms), 4; Tuberculosis, 5; Dysentery, 1; Diarrhoea and Enteritis (under 2 years), 1. Other deaths under 1 year, 9. Other deaths over 1 year, 13. Stillbirths, nil.

Anterior Poliomyelitis—Only 49 cases to date this year. We have been very fortunate in comparison with many states and provinces.

Diphtheria—Too many cases again this year. A good New Year's resolution is "I will redouble my efforts to have every child and young adult immunized against diphtheria."

Measles and Mumps have both shown increased incidence in 1946.

Typhoid Fever—If we have no epidemics in the final two weeks of the year we expect the least number of cases for any year in Manitoba's history. But our sanitation can still be improved to a great extent!



Allenburys BYNIN AMARA

AFTER INFLUENZA, PNEUMONIA AND OTHER ACUTE INFECTIONS

- The general action of Bynin Amara is manifested by increased tone of the nervous, muscular, and cardio-vascular systems. It stimulates the digestive organs, improves the flagging appetite and aids nutrition generally.

The marked asthenia and nervous depression which are prominent features of the post-influenzal state, yield rapidly to its influence. A course, whenever there is any indication of lowered resistance, is a valuable safeguard against infection.

Available in 10 oz., 80 oz., and 160 oz. bottles.

Complete literature supplied on request.

THE ALLEN AND HANBURY'S COMPANY LIMITED
LINDSAY, ONTARIO
LONDON, ENGLAND

College of Physicians and Surgeons of Manitoba

Annual Meeting Report

(Continued from December issue)

Council Meeting

October 16, 1946

Education Committee.

See report under business arising from May, 1946, special Council Meeting.

Finance Committee.

No meeting.

Legislative Committee.

No meeting.

Library Committee.

As Dr. Bruce Chown was not present at this meeting, Dr. W. G. Campbell presented the Library statistics as compiled by Miss Ruth D. Monk, Librarian. He pointed out that the report shows considerable increase in the volumes and periodicals added to the Library stacks, and also a decided increase in the use of the Library particularly among the rural physicians. He also stated that should be spread abroad that rural physicians may obtain material from the Library without any cost to themselves.

Motion:

Moved and Seconded: "THAT the report of the Library Committee be adopted." Carried.

(b) Taxing Committee.

Dr. W. E. R. Coad, Chairman of the retiring Taxing Committee, prepared the following report, and Dr. W. G. Campbell presented it.

I beg to report that only one complaint was referred to your Taxing Committee since the last meeting in May of this year. This case was a complaint of an alleged overcharge for an appendectomy performed in March, 1946. The court was paid at once without hesitation and the complaint was forthcoming until four—five months later.

Your Committee carefully considered all details. A unanimous decision was made to the effect that a useful purpose could be attained by further action.

Motion:

Moved and Seconded: "THAT the report of the Taxing Committee be adopted." Carried.

Reports of Special Committees and Their Consideration.

(a) Representative to the Manitoba Medical Association Executive.

The retiring Executive Committee of the Manitoba Medical Association has had a very busy year. Nine regular meetings were held, all but one on Monday afternoon beginning at 2.00 p.m. and extending late into the evening. One meeting was rearranged to suit the C.M.A. representatives.

In March, 1946, a two-day extra business meeting was required to dispose of urgent matters. Then at the annual meeting, a day and evening were devoted wholly to business. These are new departures which the Executive considered warranted and have proved very satisfactory.

I will not here burden you with details as the printed reports have already been perused. The one exception was the unsatisfactory joint meeting with the College of Physicians and Surgeons.

Motion:

Moved and Seconded: "THAT the report of the representatives to the Manitoba Medical Association Executive be adopted." Carried.

(b) Representatives to the Committee of Fifteen.

No meeting.

(c) Representative to the Committee on Admissions.

As Dr. H. Bruce Chown was absent from the meeting, Dr. W. G. Campbell presented his report as follows:

The selection of medical students for the current year was particularly difficult. The Board of Governors laid down the general rule that preference should be given to veterans and to graduates and under-graduates of the University of Manitoba. Among the applicants there were three groups of students—those who had completed the two years pre-medical requirements; those that had taken further work, up to their B.A. or B.Sc.; and finally applicants from outside the province. No student who was not an under-graduate or graduate of the University of Manitoba was considered although the impression has gone abroad that students from other provinces were accepted. This impression is based on the fact that students whose homes were not in the province but who carried on their studies at the University of Manitoba were among those who were selected.

The first meetings of the Committee were held in April and May when a general plan on selection was laid down. This included personal interviews by a panel of five together with letters of reference from previous teachers, etc. As it turned out the plan was quite impossible of completion because the final class of students did not complete their examinations until the 18th of July and the whole list of applicants was not available until nearly the 1st of August. Accordingly the plans of selection were simplified and for each student a letter was sent to each of the three references whose names were given in the students application, and a questionnaire to the heads of the Departments of English, Chemistry, Physics, Botany and Zoology. These documents proved of very little value so that the final selection was made on the basis of marks. The mark used was

the average of the student's University course whether that course was two years, three years or four years.

There were 327 applicants of whom 152 were returned personnel and 175 civilian personnel. It was decided to make the class 67% returned personnel and 33% civilian. Accordingly 46 veterans were accepted and 106 refused; 24 civilians accepted and 151 refused. The lowest average mark among the civilians was 69.8 and among the veterans 64.4.

About the 1st of August the Committee was asked to increase the number of students from 60 to 70 and then from 70 to 90, in spite of inadequate teaching staff and accommodation. The number was increased to 70, and when the Board of Governors heard the reports of the Committee of the Medical Faculty on the impossibility of further increase, the Board of Governors at that time decided to hold the number of admissions to 70 and not to increase it to 90.

Since it is the function of the College of Physicians and Surgeons to determine whether or not an individual is qualified in Medicine that he may be licensed to practice, this question of admission of students is vital to the College. As you are aware pressure is being brought on the University to increase the present class and to admit a second class in January. I would earnestly request that a Committee of the College be set up to study the problem and make such representation as may be necessary to those in authority.

Motion:

Moved and Seconded: "THAT the report of the representative to the Committee on Admissions be accepted." Carried.

Motion:

Moved and Seconded: "That Dr. H. Bruce Chown's request be referred to the Education Committee, and the representative on the Committee on Admissions, Dr. Chown." Carried.

(d) Representatives to the Medical Council of Canada.

Dr. J. S. Poole read the letter from Dr. Wm. Turnbull, stating that as he was no longer a member of the Council of the College of Physicians and Surgeons of Manitoba, that he resigned his appointment as a Manitoba representative to the Medical Council of Canada. Accepted.

Dr. Poole presented the following report:

The Medical Council of Canada met in Ottawa on September 4, 1946.

The application of Dr. L. Jamieson to become a licentiate of the Council was considered and the opinion of the majority was that the antedating of his registration by the Manitoba College of Physicians and Surgeons, was not binding on the Council, and the final decision of the matter was deferred.

The standing of Professors from abroad taken up on the initiative of the Ontario representatives. The opinion was expressed that Council might appoint a committee to consider the standing of these men, and probably advise the Council to admit them to the Licentiate without examination. Many of the members of Council thought this a Provincial matter that could best be solved by each of the Provinces having reciprocity with Great Britain, as most of our Professors come from that country.

A committee was appointed to review the Dominion Medical Act and report to Council with reference to any change which might be thought advisable.

511 Licentiates were added to the roll in the past year; all by examination.

Motion:

Moved and Seconded: "That the report of representatives to the Medical Council of Canada be adopted." Carried.

(e) Representative to the University Senate.

As Dr. W. E. R. Coad was not present at the meeting, Dr. W. G. Campbell gave his report as follows:

As representative of the College of Physicians and Surgeons on the University Senate of Manitoba, I am pleased to advise you that since my last report in May, 1946, there were only two regular meetings of the Senate, both of which I attended.

The chief item of interest within that period was the operation of the Basic Science Act and a committee selected by the University Senate to study which I am one of its members. This Basic Science Committee held four meetings, carefully reviewed the credentials of all applicants who applied for Certificates of Credit—a very necessary testimony asked for before the issue of a license to practice legal medicine in the Province of Manitoba. Established.

There were 76 applications from graduates of the University of Manitoba, 2 from Alberta, 1 from Toronto, and 1 from Queens. All of these applications, 86 in all, were approved by the Basic Science Committee, and immediately referred to the University Senate for approval. All were approved. Other applications were received—2 from the University of Paris, 1 from Vienna and 1 from Edinburgh. These will be dealt with as soon as sufficient information is received as to the Basic Sciences training provided by the respective universities. Communication with these far away universities necessitates considerable delay.

It might be interesting to know that the Basic Science Committee convenes two days before the regular monthly meeting of the Senate, in order to avoid unnecessary delay in issuing the Certificates of Credit.